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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5722  
CERTIFICATE OF DEATH  
05711

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>15 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grace Ellen Aber</b>		4. DATE OF DEATH Month Day Year <b>5 20 19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/83</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Indiana, USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Milton Quyle</b>		14. MOTHER'S MAIDEN NAME <b>Susan Chowning</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pneumonia, left lung; atrial fibrillation.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/5/61</b> to <b>5/20/61</b> , that (I) (we) last saw the deceased alive on <b>5/5/61</b> , and that death occurred at <b>5/20/61</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>G. F. Meadors, M.D.</i>		22b. DATE SIGNED <b>5/20/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.F. Meadors, M.D.</b>		22d. ADDRESS <b>Main Street, Damascus, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>May 22, 1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber</i>		25a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>	
ADDRESS <b>Laytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kline</i>	

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FOR STATE  
HEALTH DEPT.

TO JURY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5723 06870

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>seven years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>192 Fleetwood Terrace</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>192 Fleetwood Terrace</b>			
3. NAME OF DECEASED (Type or print) <b>Charles Edward Ackerman Jr.</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 8, 1889</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Budget &amp; Fiscal officer</b>		11. BIRTHPLACE (State or foreign country) <b>Peekskill New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Edward Ackerman, Sr., New York</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Braceling</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW2</b>				16. SOCIAL SECURITY NO. <b>215-26-3654</b>			
17. INFORMANT <b>Mr. Charles E. Ackerman, 1913 Eries St. W. Hyattsville, Md.</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.4 Pulmonary Insufficiency</b> DUE TO (b) <b>Pulmonary Emphysema</b> DUE TO (c) <b>Cor pulmonale</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Found dead in bed 2 years</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschelt</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschelt</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <b>6-1-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/5/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery Arlington County, Virginia</b>	
23. FUNERAL DIRECTOR Address <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 7 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>	

MEDICAL CERTIFICATION





TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item 8 Film G-68 6/1/61 1wk											
65712											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>21 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>Rt #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Peggy</u> First <u>N</u> Middle <u>Adams</u> Last 4. DATE OF DEATH Month <u>5</u> Day <u>17</u> Year <u>1961</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/10/7/11/1922</u>		9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Hamilton</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Mosley</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Heroy Adams (husband)</u> Address <u>same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (b) <u>Perforated Gastric Ulcer</u> 2mo (a), stating the underlying cause last, (c) <u>CARCINOMA, stomach</u> 9mo PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>5-16</u> <u>1961</u> to <u>5-17</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>5-17</u> <u>1961</u> , and that death occurred at <u>6:09 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>J. Roscoe Creever M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. Roscoe Creever</u>				22d. ADDRESS <u>1800 Eye St. N.W. Wash. 6 D.C.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>SHIPPED</u>		23b. DATE THEREOF <u>5/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>THOMPSON &amp; CARPENTER FUN.</u>				23d. LOCATION (City, town or county) (State) <u>HOME, SPARTANBURG, S. C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>ROCKVILLE, MD.</u>				25a. REC'D BY REGISTRAR <u>MAY 24 '61</u> DATE				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>			

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Expanded question  
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THOMSON & COMPANY, INC., NEW YORK, N.Y.  
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TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5125

05712

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Koma Park</u> c. LENGTH OF STAY IN lb <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitation &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Koma Park</u> d. STREET ADDRESS <u>7113 Poplar Avenue</u>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles H. Alexander</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>16</u> Year <u>1961</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-1-78</u>									
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs. <table border="1"> <tr> <td colspan="2">UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Salesman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Paper Products</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Hungary</u>	
UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>				<b>13. FATHER'S NAME</b> <u>Sigmond Alexander</u>											
<b>14. MOTHER'S MAIDEN NAME</b> <u>Heleen (unknown)</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u>											
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>SON-IN-LAW</u> Address <u>Mt Marty Gettleman 7113 Poplar Ave. La Koma Park</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> (b) <u>Pyelonephritis</u> (c) <u>Diabetes mellitus; Paget's Disease of Bone</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>															
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)															
<b>20c. TIME OF INJURY</b> Hour <u>19</u> e.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)									
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/16</u> , 19 <u>61</u> , to <u>May 16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 16</u> , 19 <u>61</u> , and that death occurred about <u>8:00 P.M.</u> from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Norman H. Rubenstein</u>				<b>22b. DATE SIGNED</b> <u>5/17/61</u>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>NORMAN H. RUBENSTEIN</u>				<b>22d. ADDRESS</b> <u>6480 N.H. Ave. Takoma Park, Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>May 19, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rabbi Isaac Elchovan Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Everett, Mass.</u>									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldkey Funeral Home</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAY 18 '61</u>											
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>				<b>25c. ADDRESS</b> <u>4207-9th St NW</u>											

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TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5726

05714

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Erie</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Erie</u> d. STREET ADDRESS <u>533 Shenley Drive</u>								
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mildred Marie Anderson</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> - Day <u>18</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>10-11-05</u>	<b>9. AGE</b> (In years last birthday) <u>56</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Erie, Penna</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>								
<b>13. FATHER'S NAME</b> <u>Frank Anderson</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Butzer</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hosp Records</u> Address								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X</u> DUE TO <u>Carcinoma of pancreas (head)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic</u> (a), stating the underlying cause last. (c)					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u> <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 13, 1961</u> <b>to</b> <u>May 18, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 18, 1961</u> , <b>and that death occurred at</b> <u>8:25 P.</u> <b>M.</b> <b>from the causes and on the date stated above.</b>												
<b>22a. SIGNATURE</b> <u>Raymond O. West</u> M.D.		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>RAYMOND O. WEST</u>		<b>22d. ADDRESS</b> <u>7600 Carroll Ave. Takoma Park, Md.</u>										
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>May 24, 1961</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Home Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) <u>Youngstown, Ohio.</u> (State)									
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Carroll Rd NW DC</u>		<b>ADDRESS</b>	<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAY 22 '61</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Huns</u>								



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FOR STATE  
HEALTH DEPT.

5727  
MONTGOMERY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05715

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dawsonville  
c. LENGTH OF STAY IN 1b 9 yr  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Ind R-121 - Boyle

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  
a. STATE md b. COUNTY Montg  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dawsonville  
d. STREET ADDRESS Ind R-121 Boyle

3. NAME OF DECEASED (Type or print) Harvey Appleman  
4. DATE OF DEATH May 26 1961

5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 9-28-'71 9. AGE (In years, last birthday) 89 10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Board Employee 10b. KIND OF BUSINESS OR INDUSTRY Ohio 11. BIRTHPLACE (State or foreign country) Ohio 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lois Appleman 14. MOTHER'S MAIDEN NAME Rose Daniel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 133 Aldrich Rd Columbus Ohio 17. INFORMANT Margaret Peters Address 133 Aldrich Rd Columbus Ohio

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Central gunshot + laceration  
DUE TO (b) bullet wound in skull  
DUE TO (c) sudden

CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted bullet wound in skull

20c. TIME OF INJURY Month, Day, Year 5-26-1961 20d. INJURY OCCURRED While ☒ Not While ☐ at work ☐ et work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Dawsonville (County) Montg (State) md

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 5-26-61

EXAMINER'S NAME (Type) FRANK J. Broschart DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county) South Bend Indiana

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 29-61 22c. NAME OF CEMETERY OR CREMATORY River Forest 22d. LOCATION (City, town, or country) (State) South Bend Indiana

23. FUNERAL DIRECTOR Willard C. Helton, Bensenville, Ind 24a. REC'D BY REGISTRAR DATE MAY 31 '61 24b. REGISTRAR'S SIGNATURE C. J. S. Kline



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

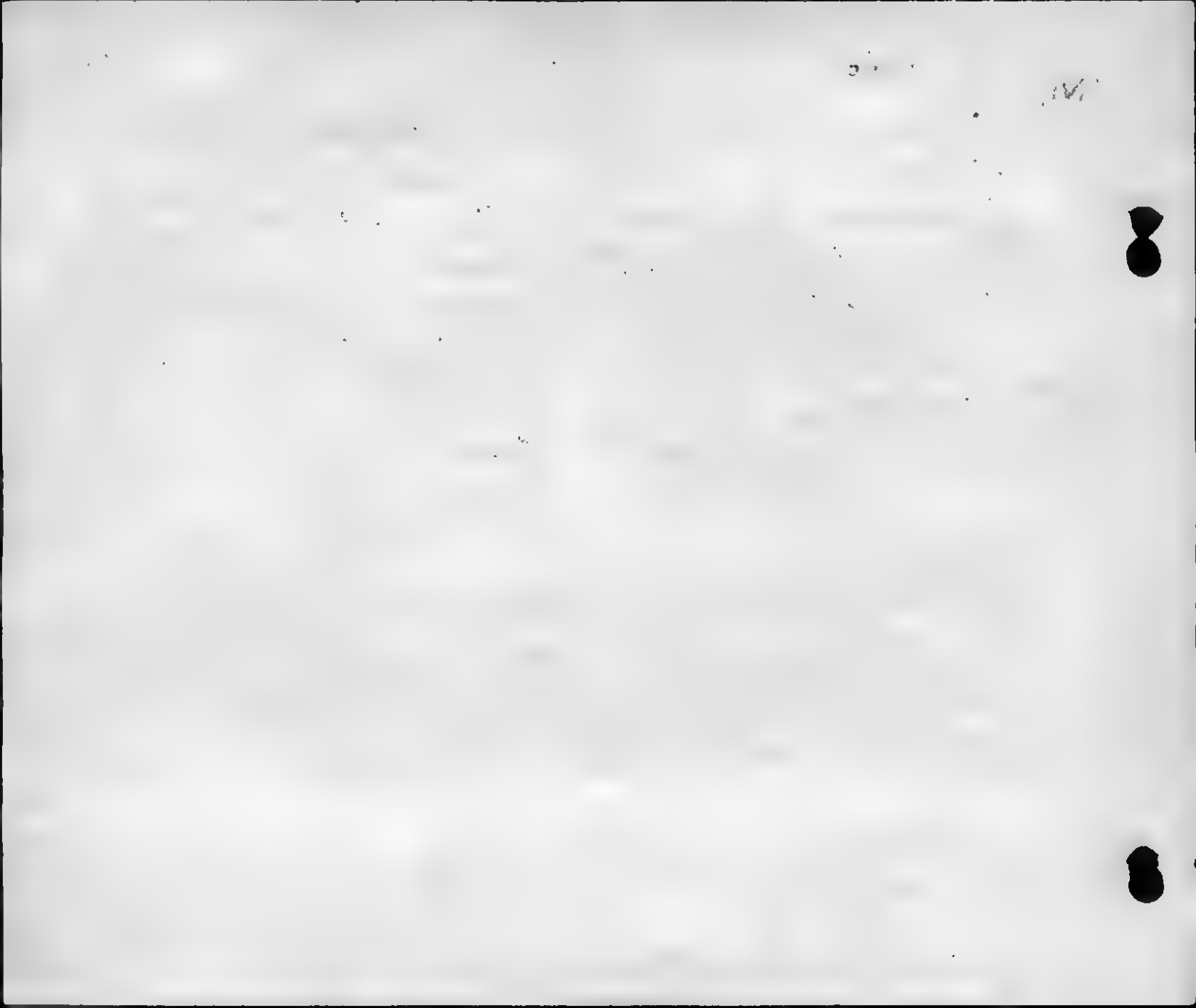
## CERTIFICATE OF DEATH

5728

05717

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution, give name of institution) e. STATE <u>Maryland</u> f. COUNTY <u>Montgomery</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> h. STREET ADDRESS <u>9430 R. S. Ave.</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry C. Ston Ashby</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>6</u> Day <u>7</u> Year <u>1906</u>
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>us. Gov't Retired</u>		10. KIND OF BUSINESS OR INDUSTRY <u>CHARTERER</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MARRIAGE NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Hosp record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO (b) <u>None</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Hosp record</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>61</u> to <u>5/14</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> , 19 <u>61</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold T. Morse</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HAROLD T. MORSE</u>		22d. ADDRESS <u>7030 W. Ave. Jakoma Park and</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d. LOCATION (City, town or county) (State) <u>Sierra Vista Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. J. ...</u> ADDRESS <u>5801 E. ...</u>		25. REC'D BY REGISTRAR <u>MAY 12 '61</u>	
25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	

TO BE FILLED BY ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law also requires that the death certificate be completed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO THE COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it may be executed at any time after death. It should be executed by the County Medical Examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

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FOR STATE  
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 10-21, Film G-207 3/13/61-cac											
05718											
1. PLACE OF DEATH a. COUNTY		Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		Maryland		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Takoma Park		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Takoma Park		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		Washington San & Hospital		d. STREET ADDRESS		7335 Carroll Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		Robin Louise Atchley		4. DATE OF DEATH		May 1 1961		9. AGE (in years, if UNDER 1 YEAR, if UNDER 24 HRS, by birthday)		19	
5. SEX		female		6. COLOR OR RACE		white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
										2/14/60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)		Maryland	
13. FATHER'S NAME		Euel Atchey		14. MOTHER'S MAIDEN NAME		Esther Nixon		12. CITIZEN OF WHAT COUNTRY?		USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO		Euel Atchey		17. INFORMANT		Address Item 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (c))		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE		871.0		DUE TO		Blood contained 20 mg. Meprobamate		Liver contained 16mg. Meprobamate.	
		Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)		DUE TO					
				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		Took Miltown tabs. at home.		20c. TIME OF INJURY		Month, Day, Year	
								4-9-1961			
								20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
								Home		Taloma Park, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspect on <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Frank J. Broschart		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		Frank J. Broschart								DATE SIGNED	
										5/2/61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		22b. DATE THEREOF		May 3, 1961		22c. NAME OF CEMETERY OR CREMATORY		George Washington Cemetery	
										Prince Georges County, Md.	
23. FUNERAL DIRECTOR		J. Arthur Watkins, 254 Carroll St NW		ADDRESS		A.C.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
								MAY 3 '61		Arthur S. Thomas	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

- Item 14 Film G288 6/12/61 mb

05719

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FOR STATE  
HEALTH DEPT.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Ullery

c. LENGTH OF STAY IN 1b

DOA

d. NAME OF HOSPITAL OR INSTITUTION (if not a hospital, give street address)

Monty Gen. Hosp

### 3. NAME OF DECEASED

(Type or print)

Helena Wellinia Baier

### 5. SEX

Female

### 6. COLOR OR RACE

White

### 7. MARRIED

NEVER MARRIED ☒

### 8. DATE OF BIRTH

9-5-1881

### 9. AGE (in years, if UNDER 1 YEAR, last birthday)

79 yrs.

### 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Cook

### 10b. KIND OF BUSINESS OR INDUSTRY

### 11. BIRTH PLACE (State or foreign country)

Va

### 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

Geo Baier

### 14. MOTHER'S MAIDEN NAME

Elizabeth Dilger

### 15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes give year or dates of service)

no

### 17. INFORMANT

Flourence Gude (niece) Stum 2

### 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

#### PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Acute myocardial infarction  
Coronary Thrombosis

### INTERVAL BETWEEN ONSET AND DEATH

sudden

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

### 20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

### 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

### 20c. TIME OF INJURY

Hour e.m. p.m.

Month. Day. Year

19

### 20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

### 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

### 20f. (City or town)

### (County)

### (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

### ACTUAL SIGNATURE

Frank J. Boschert

M.D.

### EXAMINER'S NAME (Type)

FRANK J. BOSCHERT

### CHIEF MEDICAL EXAMINER ☐

### ASSISTANT MEDICAL EXAMINER ☐

### DEPUTY MEDICAL EXAMINER ☒

### DATE SIGNED

5-31-61

Address (Street, city, town, or county)

### 22d. LOCATION (City, town, or country)

### (State)

Alexandria Virginia

### 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 22b. DATE THEREOF

6/3/61

### 22c. NAME OF CEMETERY OR CREMATORY

Bethel Cemetery

### 23. FUNERAL DIRECTOR

P. Gasch's Sons Hyattsville, Md.

### 24a. REC'D BY REG STRAR

### 24b. REGISTRAR'S SIGNATURE

DATE JUN 2 '61

Arthur L. Kraus

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, the medical director, in pencil in item 18, Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH

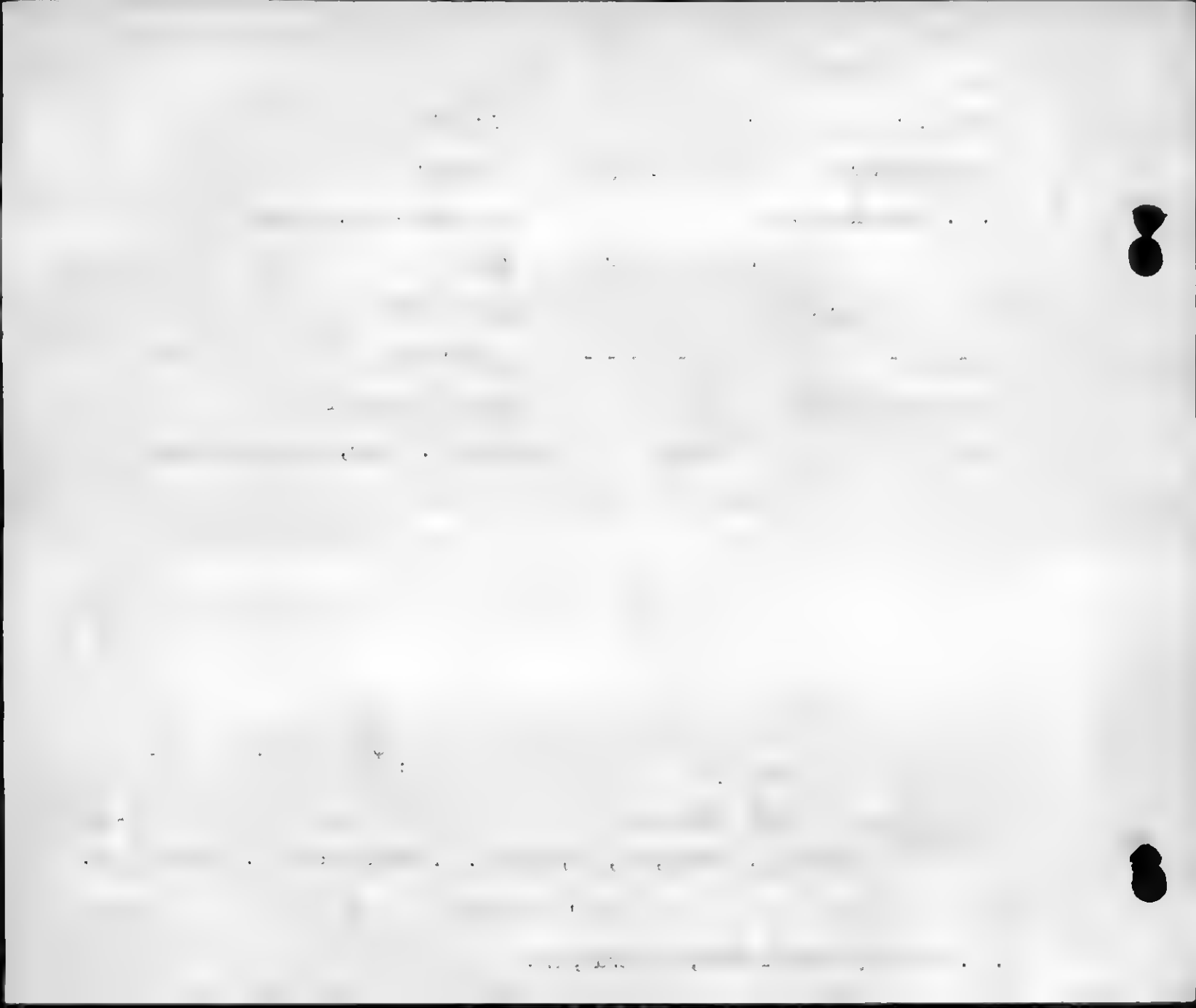
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>4535 Taney Ave. - Apt. 203</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anthony Edward BAKER</b>		4. DATE OF DEATH <b>May 15 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 14, 1961</b>	
9. AGE (In years last birthday) <b>16</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>16</b> Hours <b>23</b> Min.	
11. BIRTHPLACE (Country & State) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Edwin BAKER</b>		14. MOTHER'S MAIDEN NAME <b>Lea Marie FERRARI</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(F) George E. Baker, same as #2 above</b>	
17. INFORMANT <b>(F) George E. Baker, same as #2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 hrs. 23 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>May 14 1961</b> to <b>May 15 1961</b> , that (we) last saw the deceased alive on <b>May 15 1961</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Lawrence G. Thorne</b>		22b. DATE SIGNED <b>5-15-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lawrence G. THORNE, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>5-16-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Norfolk Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, D.B.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. ADDRESS <b>Bethesda, Md.</b>	

2051212-1

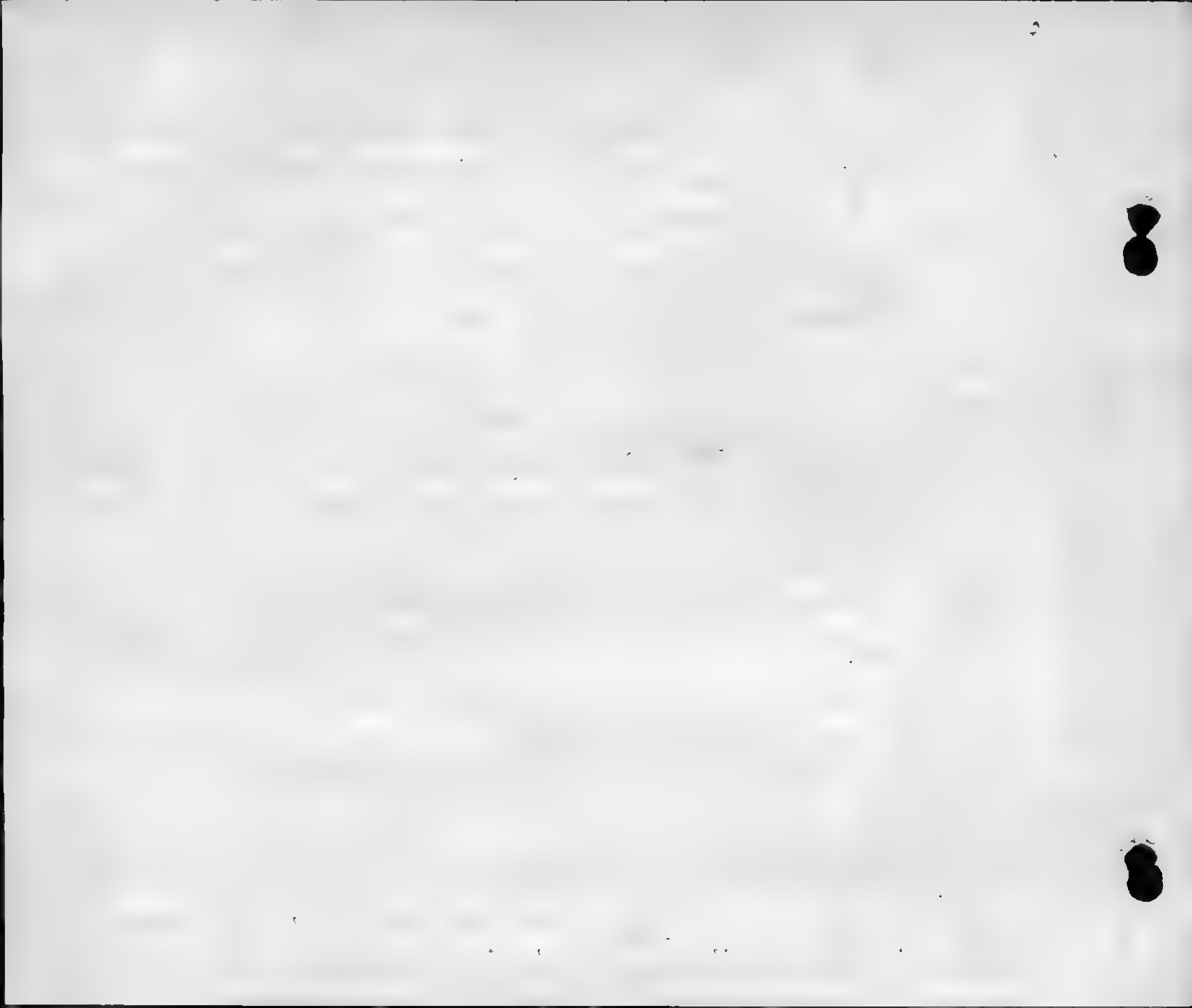




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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
c. LENGTH OF STAY IN 1b <u>2 hrs</u>		d. STREET ADDRESS <u>2620 Colston Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>meth. Church - E. W. City &amp; York Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas Harvey Baker</u>		4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-1907</u>
9. AGE (In years, last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR, IF UNDER 24 HRS. Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>meth.</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harvey Baker</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-2921</u>	
17. INFORMANT <u>Eliz. Baker (wife)</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>History of previous Coronary disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschani</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSHANI</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 29, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Park Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc., Silver Spring, Md.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 1 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



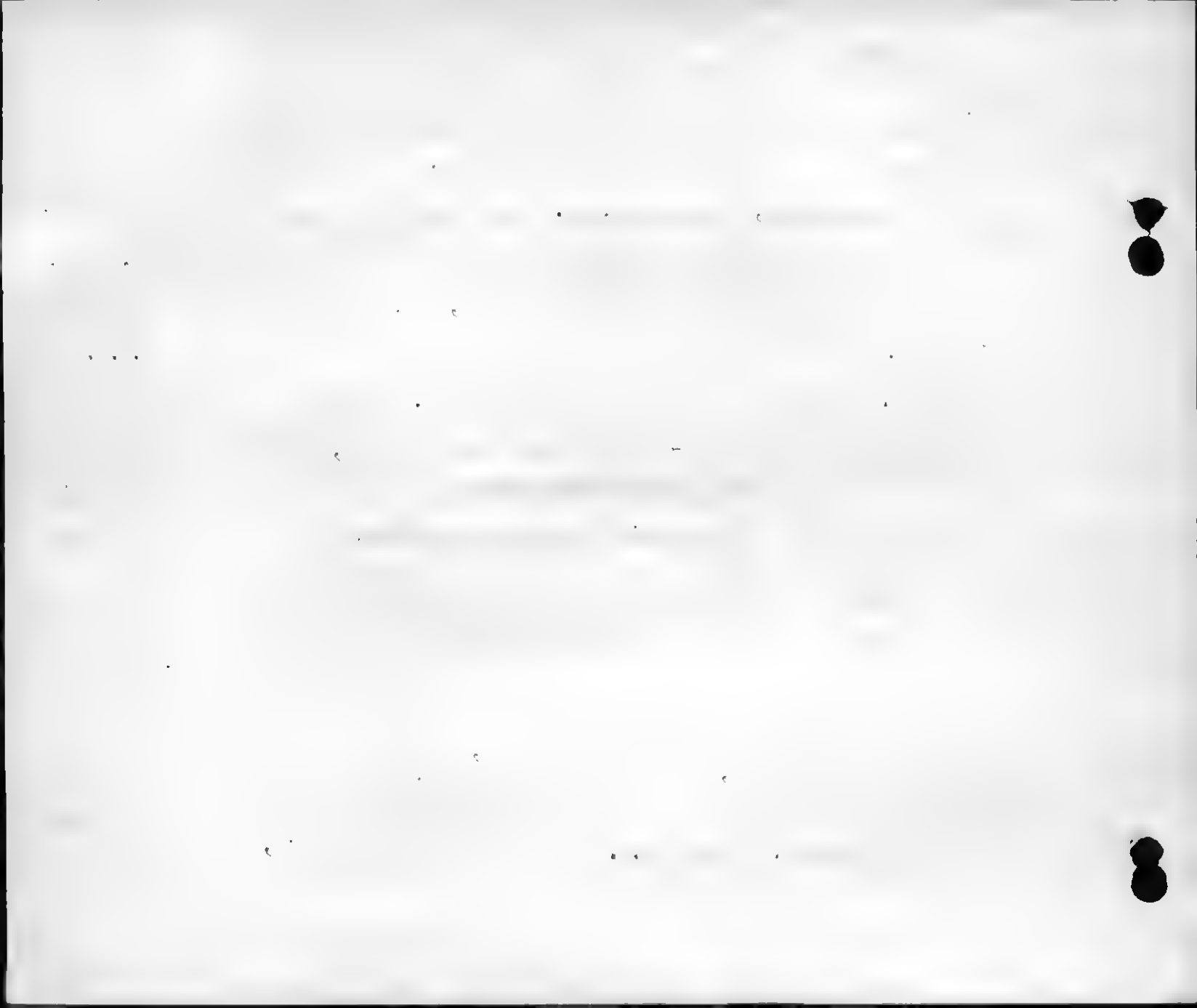
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5733

05722

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Fanwood</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>167 Belvidere Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Katherine Beatrice Bateman</b>				4. DATE OF DEATH Month Day Year <b>May 14, 1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1918</b>	
9. AGE (In years lost birthday) <b>42 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harold W. Ireland</b>				14. MOTHER'S MAIDEN NAME <b>Olive B. Hambley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>146-32-2351</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>  <b>8 years</b>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 11, 1961</b> to <b>May 11, 1961</b> , that (I) (we) lost saw the deceased alive on <b>May 14, 1961</b> and that death occurred on <b>May 14, 1961</b> from the causes and on the date stated above							
22a. SIGNATURE <i>Thomas E. Gaffney</i>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> M.D.		22b. DATE SIGNED <b>5/15/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS E. GAFFNEY, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>—</b>		23d. LOCATION (City, town, or county) (State) <b>Toronto, Canada</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i>				ADDRESS <b>3072 - M St NW Wash DC</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the aid of the attending physician. The low requires that the death certificate be executed with the aid of the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

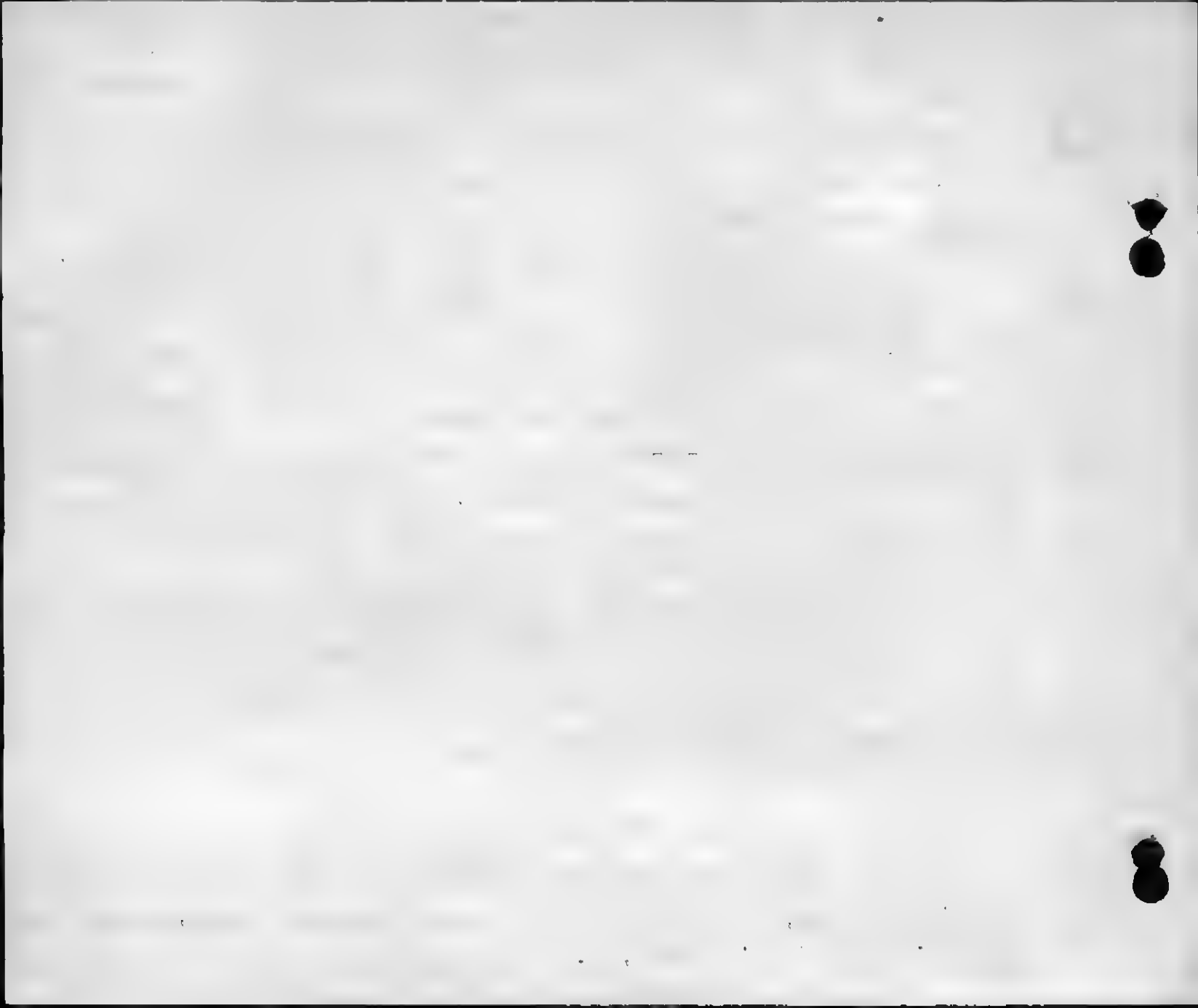
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**1**  
**FOR STATE**  
**HEALTH DEPT.**

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, it may be extended to 72 hours after death. The certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3515 Plym's mill ct.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3515 Plym's mill ct.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Henry</u> <b>4. DATE OF DEATH</b> <u>May 22 1961</u> 9. AGE (in years last birthday) <u>77</u> 10. F. UNDER 1 YEAR IF UNDER 24 HRS. Months <u>22</u> Days <u>2</u> Hours <u>1</u> Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11-7-1913</u> <b>9. WIDOWED</b> <input type="checkbox"/> <b>10. DIVORCED</b> <input type="checkbox"/>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>N. Y.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accountant</u> <b>11. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN</u>		<b>13. FATHER'S NAME</b> <u>Carlo Bauer</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Victoria Tatusik</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>225-05-0294</u> <b>17. INFORMANT</b> <u>Wivian Bauer (wife)</u> Address <u>Stuen 2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>History of previous Cornary disease</u> DUE TO (e), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).</b> <u>History of previous Cornary disease</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II. of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>Frank J. Bluschatz</u> <b>MD</b> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Bluschatz</u> <b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u> <b>22b. DATE THEREOF</b> <u>May 25, 1961</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PARKLAWN CEMETERY</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASS. STANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street city town or county) <u>Montgomery County, Maryland</u> <b>22d. LOCAT ON</b> (City, town, or country) (State) <u>5-22-61</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u> <u>Raymond A. Asha</u> <u>Silver Spring, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>MAY 29 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Carlton L. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5735

05724

Item 2 Mm 6287 5/22/61 mh

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL — SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C. Rockville 13</b>	
c. LENGTH OF STAY IN 1b <b>5 YRS.</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SEYMOUR NURSING HOME</b>	
e. STREET ADDRESS <b>14700 Crossway Rd.</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TERESA</b> Middle <b>V</b> Last <b>BAZZURO</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-21-1881</b>
9. AGE (In years, last birthday) <b>80 yrs</b>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASH., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>BERNARD OSTMANN</b>		14. MOTHER'S MAIDEN NAME <b>MARY LOCHBOEHLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>MARY REED</b>		Address <b>14700 CROSSWAY RD. ROCKVILLE 13 MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC CARDIAC DECOMPENSATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>YEARS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 10, 1961</b> , to <b>MAY 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 12, 1961</b> , and that death occurred at <b>5A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Gene U. Cohen, M.D.</b>		22b. DATE SIGNED <b>MAY 13, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>GENE U. COHEN, M.D.</b>		22d. ADDRESS <b>931 PERSHING DR. SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/16/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		23d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Deserz Sons Co</b>		25a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
ADDRESS <b>3605-14 St NW Wash. D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



1  
FOR STATE  
HEALTH DEPT.

THIS MEDICAL EXAMINER should be executed within 24 hours after death. If necessary, the body may be retained for up to 72 hours after death. The body should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

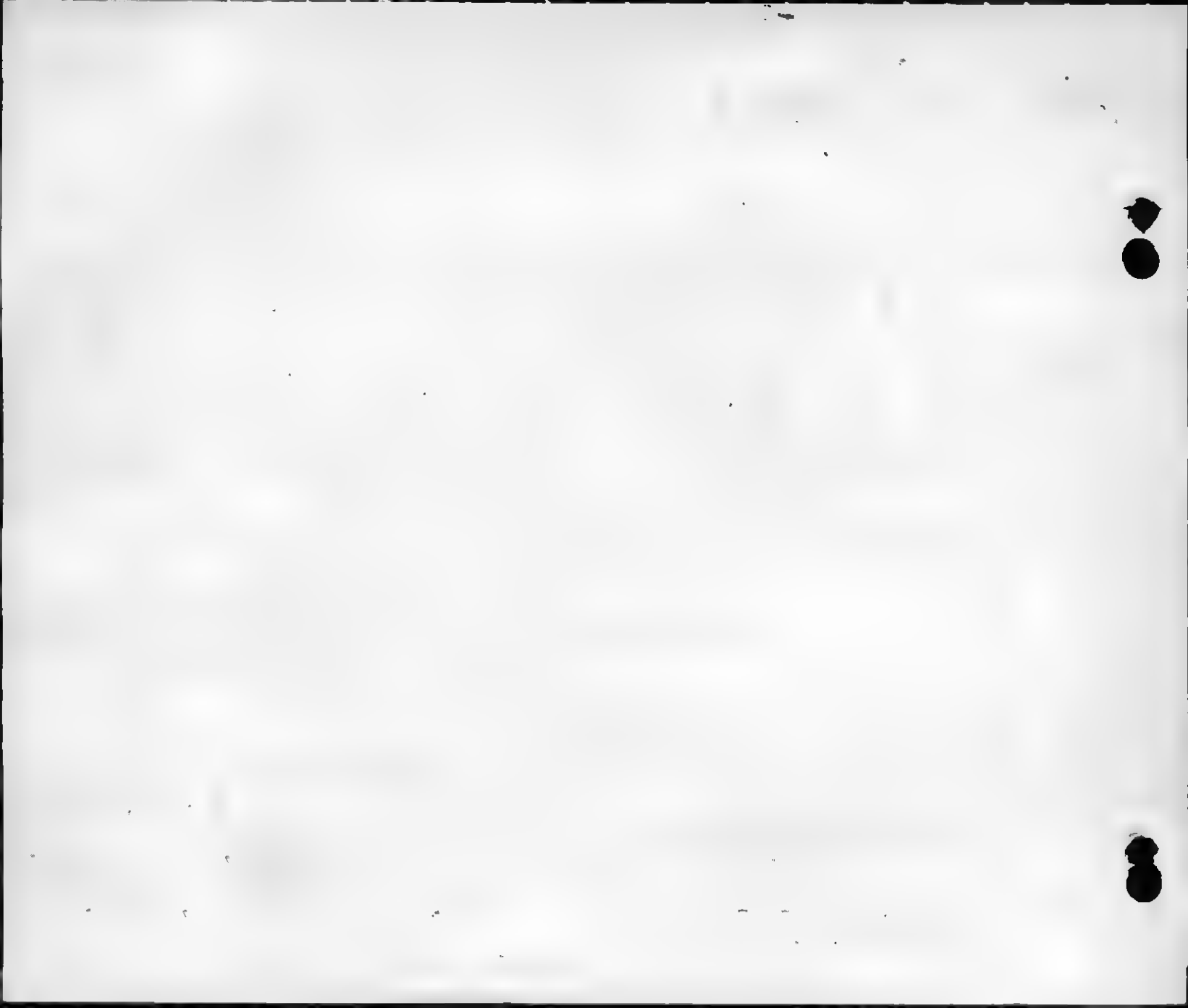
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5736 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05725

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS <u>420 Everfield Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>420 Everfield Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leah Berman</u>	4. DATE OF DEATH <u>May 3 1961</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>5-15-96</u> 9. AGE (In years, lost birthday) <u>64</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HILSEL Kramm</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Goldie Stoller -</u> Address <u>Strom</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>1204</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) <u>History of previous coronary disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death in bed</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/7/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW</u>		22d. LOCATION (City, town, or country) (State) <u>FALLS CHURCH VA</u>	
23. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217-9</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> 24b. REGISTRAR'S SIGNATURE <u>5-3-61</u>	









1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 10 & 21, Film G-287 3/13/61, Page

00727

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN IL <u>5 yrs</u>		d. STREET ADDRESS <u>19904 Southerland Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9904 Southerland Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lester S. Birely Jr.</u>	4. DATE OF DEATH <u>May 8 1961</u>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DAY OF BIRTH <u>Aug 27 1927</u>	9. AGE (In years last birthday) <u>33</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Eng.</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Vitro Corp.</u>	11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	13. FATHER'S NAME <u>Lester S. Birely</u>	14. MOTHER'S MAIDEN NAME <u>Elinor Beard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WWII</u>	16. SOCIAL SECURITY NO. <u>212-24-7359</u>	17. INFORMANT <u>Lester S. Birely</u> Address <u>Thurmont, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Combined barbiturate and alcohol poisoning.</u>			
DUE TO (b) <u>Blood contained 1.6 mg. % barbiturate and 0.29 % alcohol.</u>			
DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Thurmont, Maryland</u>	
23. FUNERAL DIRECTOR <u>Raymond E. Cragg</u>		ADDRESS <u>Thurmont, Md.</u>	
24a. REC'D BY REG. STRAR <u>MAY 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
Found dead in bed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

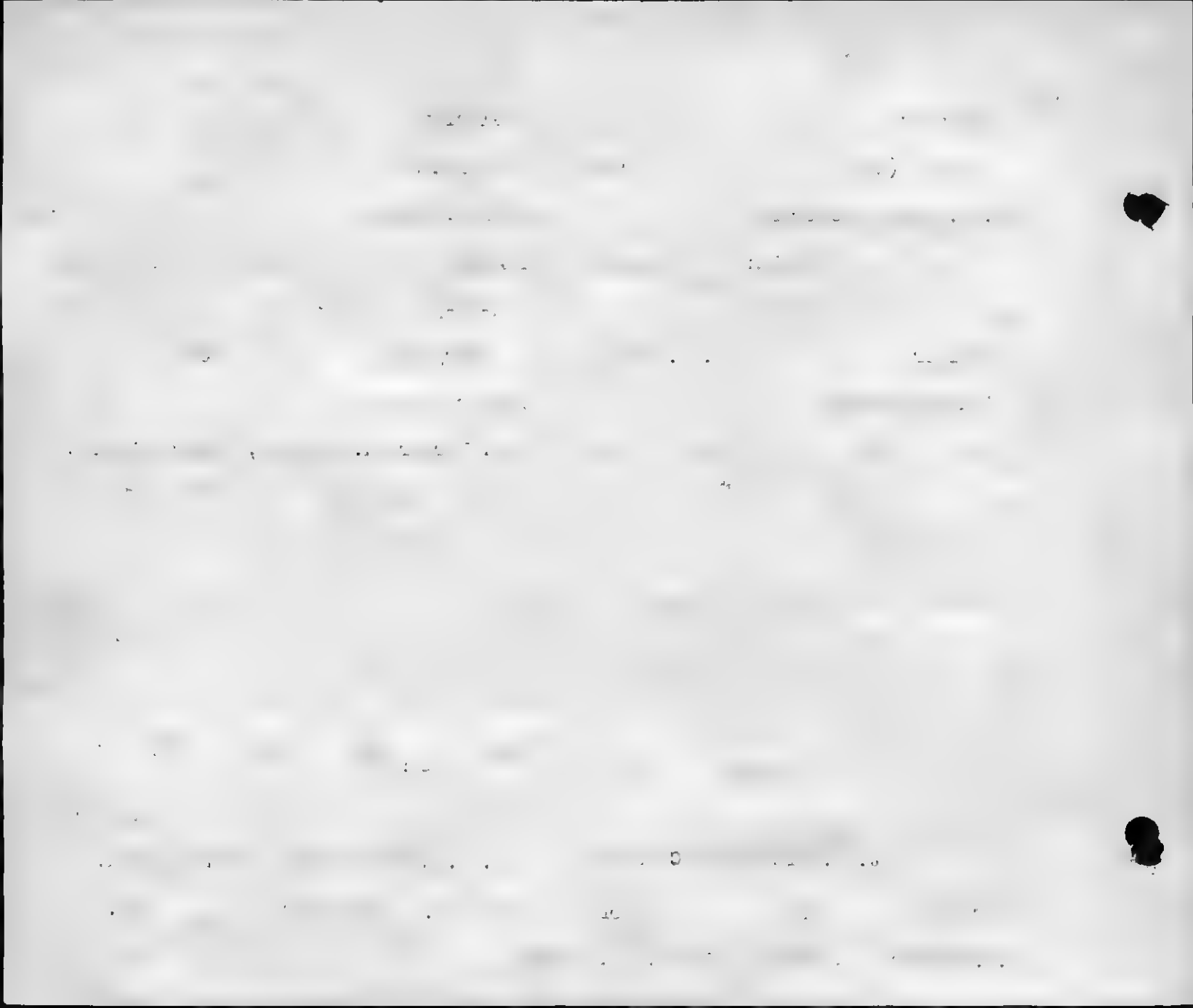
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5739

00728

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>William Douglas BLOWERS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (County & State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William BLOWERS</b>		14. MOTHER'S MAIDEN NAME <b>Margaret BAKER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-32-5885</b>		17. INFORMANT <b>(W) Mrs. Barbara K. Blowers, same as item #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS BY: 1. IMMEDIATE CAUSE (a) <b>Diffuse cerebritis and brain abscess</b> 2. DUE TO <b>unknown cause</b> 3. DUE TO <b>unknown cause</b> Conditions, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED Where White Not White at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6 May 19 61</b> to <b>16 May 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>16 May 19 61</b> , and that death occurred at <b>12:01PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>J. H. Miller</b> 22c. PHYSICIAN'S NAME (Type) <b>J. H. MILLER LT MG, USN</b>					
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
23b. DATE THEREOF <b>5-19-61</b>					
23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>					
23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 1400 Chapin St., NW, WashDC</b>					
25a. REC'D BY REGISTRAR <b>MAY 18 '61</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>					



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5740

## CERTIFICATE OF DEATH

Reg. Dist. No. 5729

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boysd</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Buck Lodge Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>H.</b> Last <b>Bolton</b>		4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min <b>78</b>	11. IF UNDER 24 HRS Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min <b>78</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (State or foreign country) <b>Montgomery Co., Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Bolton</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Anne Bolton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-16-7979</b>		INFORMANT <b>Raymond E. Justice, Mt. Airy, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> IX DUE TO <b>Cerebral Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>1 year</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>24 Dec</b> , 19 <b>60</b> , to <b>9 May</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>9 May</b> , 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b> DATE SIGNED <b>9 May 61</b>			
ACTUAL SIGNATURE <b>John W. Smith</b>		M.D. <b>Barnesville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>John W. Smith</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 12, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molesworth</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

Page 4 After death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: This certificate may be filed by the hospital or attending physician.

VS A15 (4) ISM 9/58



TO HOST: OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

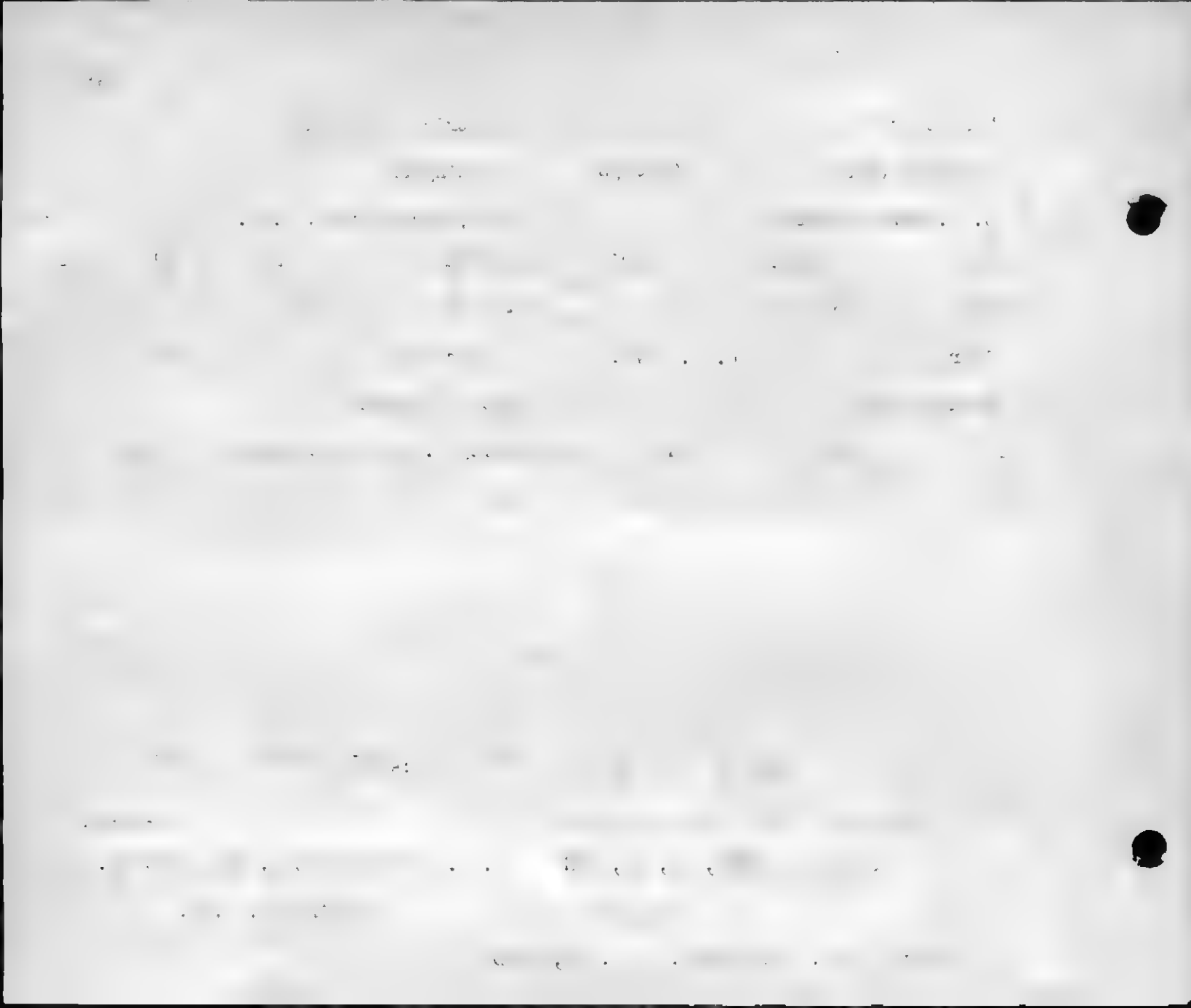
5741

## CERTIFICATE OF DEATH

65730

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY N 1b <b>29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>4117 Beck Street, S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Beulah Marie BOSWORTH</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (Country & State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Notley HOWELL</b>		14. MOTHER'S MAIDEN NAME <b>Mabel (Unknown)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>(H) Dudley C. Bosworth, same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, n.e.c. Primary</b> DUE TO <b>Unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (his hospital) attended the deceased from <b>April 20, 1961</b> to <b>May 19, 1961</b> , that (X) (we) last saw the deceased alive on <b>May 19, 1961</b> , and that death occurred at <b>2:40AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>James M. Young</b>		22b. DATE SIGNED <b>5-19-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James M. YOUNG, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/22/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home, 4th &amp; Mass. Aves., NW, WashDC</b>		24b. ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>James M. Young</b>		25c. DATE <b>MAY 23 '61</b>		25d. REGISTRAR'S SIGNATURE <b>James M. Young</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

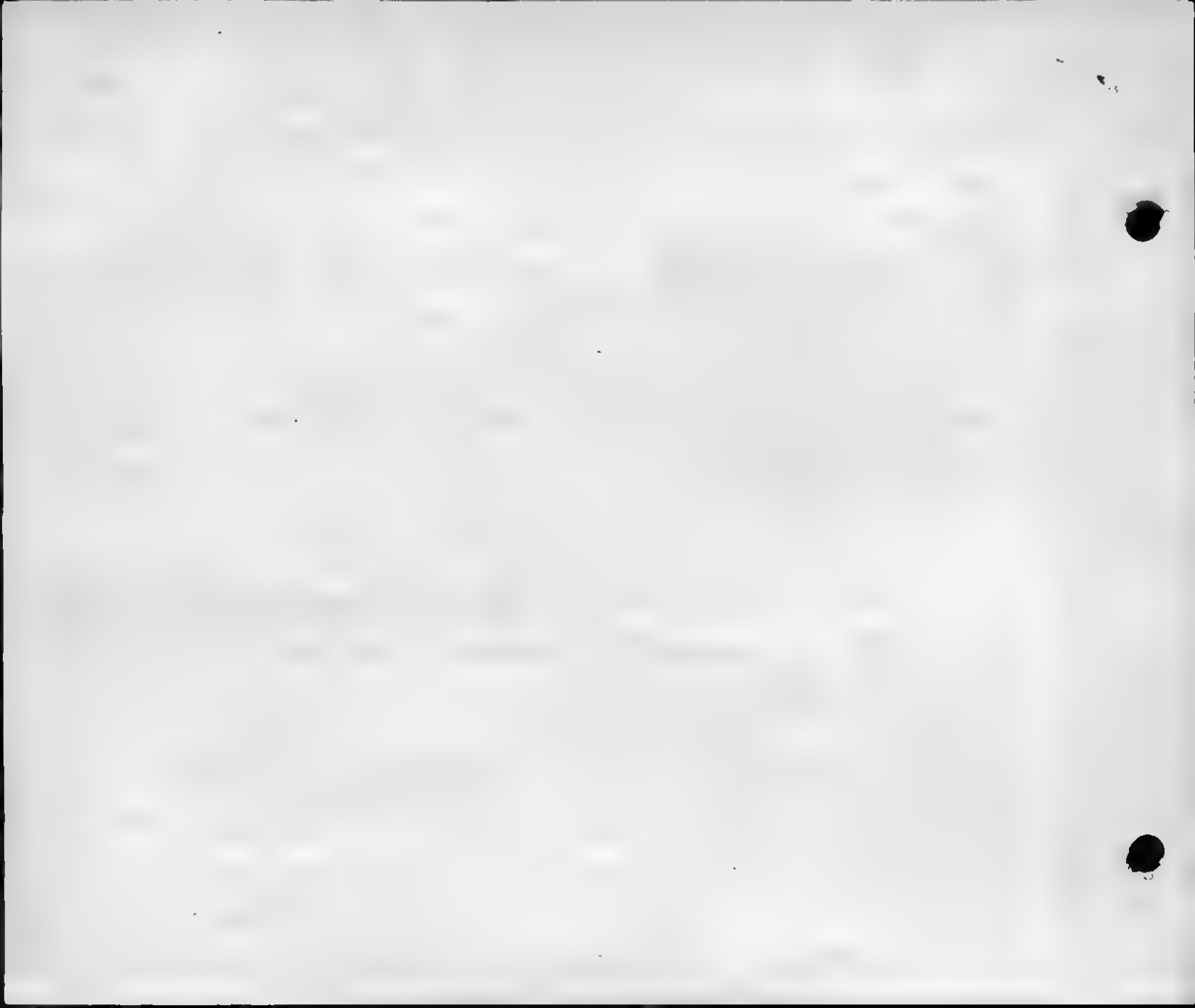
05731

FOR STATE

HEALTH DEPT

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edson Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Graft Bowie</u>		4. DATE OF DEATH <u>May 23 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>10-7-1893</u>		9. AGE (In years, last birthday) <u>67 yrs</u>		10. AGE (In years, last birthday) <u>67 yrs</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John J. Graft</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Ray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mary Ellen Brewer - Newmar - 405 La Rockville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>42 y.o.</u> (c) <u>History of previous heart disease</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>History of previous heart disease</u>					
20a. EXTERNAL CAUSE OF DEATH: PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Bioschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BIOSCHART</u>		Address (Street, c'ty, town, or county)		DATE SIGNED <u>5-23-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	
22d. LOCATION (City, town, or country) <u>Washington, D. C.</u>		22e. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		22f. REGISTRAR'S SIGNATURE <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 25 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		24c. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		24d. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5743

05732

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda (Rural)

c. LENGTH OF STAY IN 1b

3 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

U.S. Naval Hospital

### 2. USUAL RESIDENCE (Where deceased lived, 1 institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

813 Gist Avenue

a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

### 3. NAME OF DECEASED (Type or print)

First

Middle

Last

DATE OF DEATH

Month

Day

Year

THOMAS

MARSHALL

BRADY

May

1

19 61

### 5. SEX

Male

### 6. COLOR OR RACE

Caucasian

### 7. MARRIED

☒ NEVER MARRIED ☐

### 8. DATE OF BIRTH

2-2-92

### 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.)

69 yrs.

### 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

### 10b. KIND OF BUSINESS OR INDUSTRY

Maryland

### 14. MOTHER'S M A D E N NAME

Sarah Thomas

US.

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

Yes

WWI

579-12-8579

### 17. INFORMANT

Daughter

Address 813 Gist Ave

Mary Anne Brady Sinclair

Silver Spring, Md

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

420.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Infarction, myocardium  
Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

15 min

years

### PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY  
Hour a.m.  
p.m.

Month, Day, Year  
19

20d. INJURY OCCURRED  
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (a) (th's hospital) attended the deceased from 28 April 1961, to 1 May 1961, that (b) (we) last saw the deceased alive on 1 May 1961, and that death occurred at 6:04 PM from the causes and on the date stated above.

### 22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

RUSSELL MILLER, JR. LT MC USN

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☒

1 May 1961

22b. DATE SIGNED

22d. ADDRESS

U.S. Naval Hospital, Bethesda, Md

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

### 23b. DATE THEREOF

5-4-61

### 23c. NAME OF CEMETERY OR CREMATORY

Arlington National

### 23d. LOCATION (City, town or county)

Arlington Virginia

(State)

### 24. FUNERAL DIRECTOR'S SIGNATURE

W.E. PUMPHREY FUNERAL HOME, SILVER SPRING MD

### 25a. REC'D BY REGISTRAR

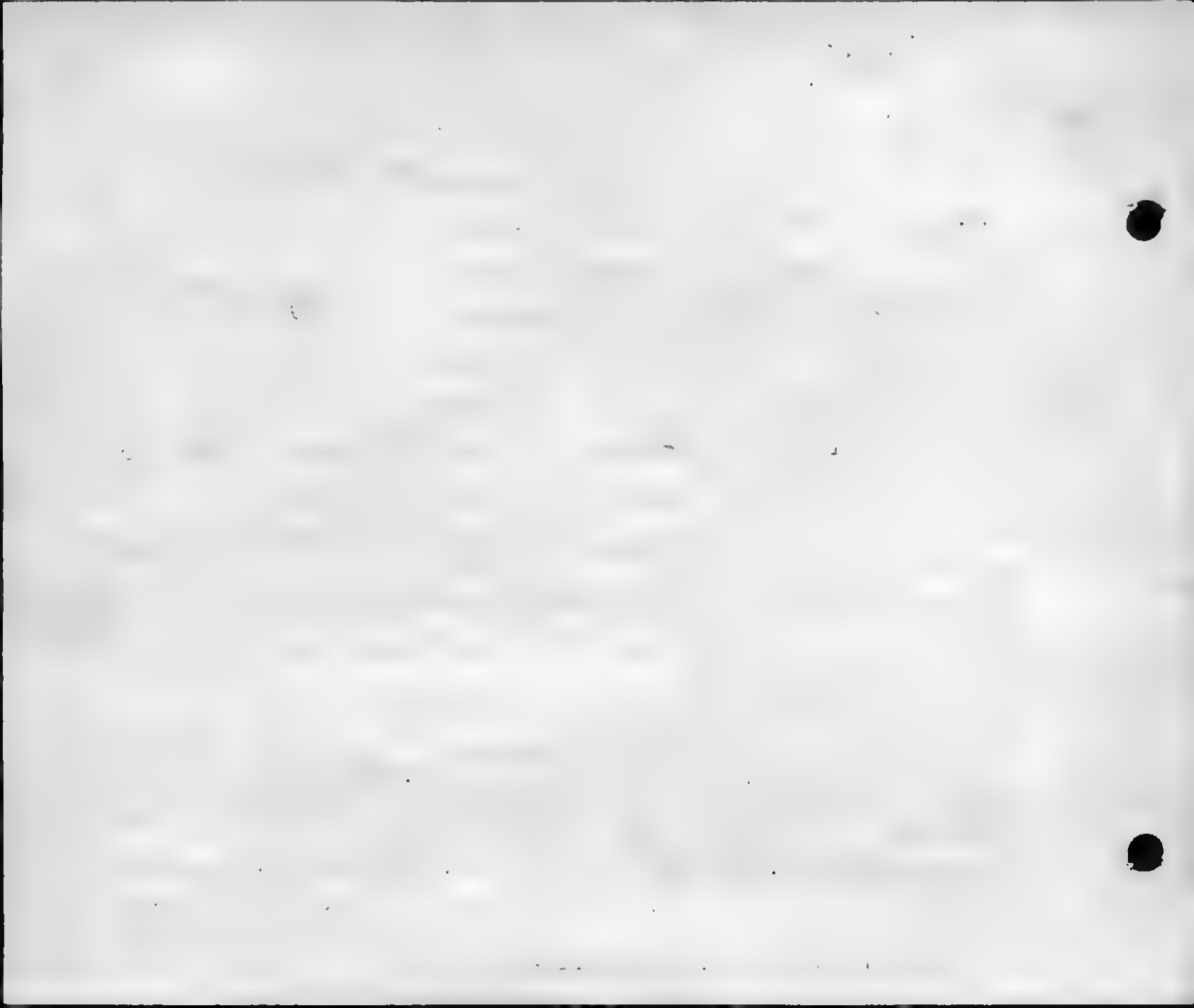
DATE MAY 4 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



5744

## CERTIFICATE OF DEATH

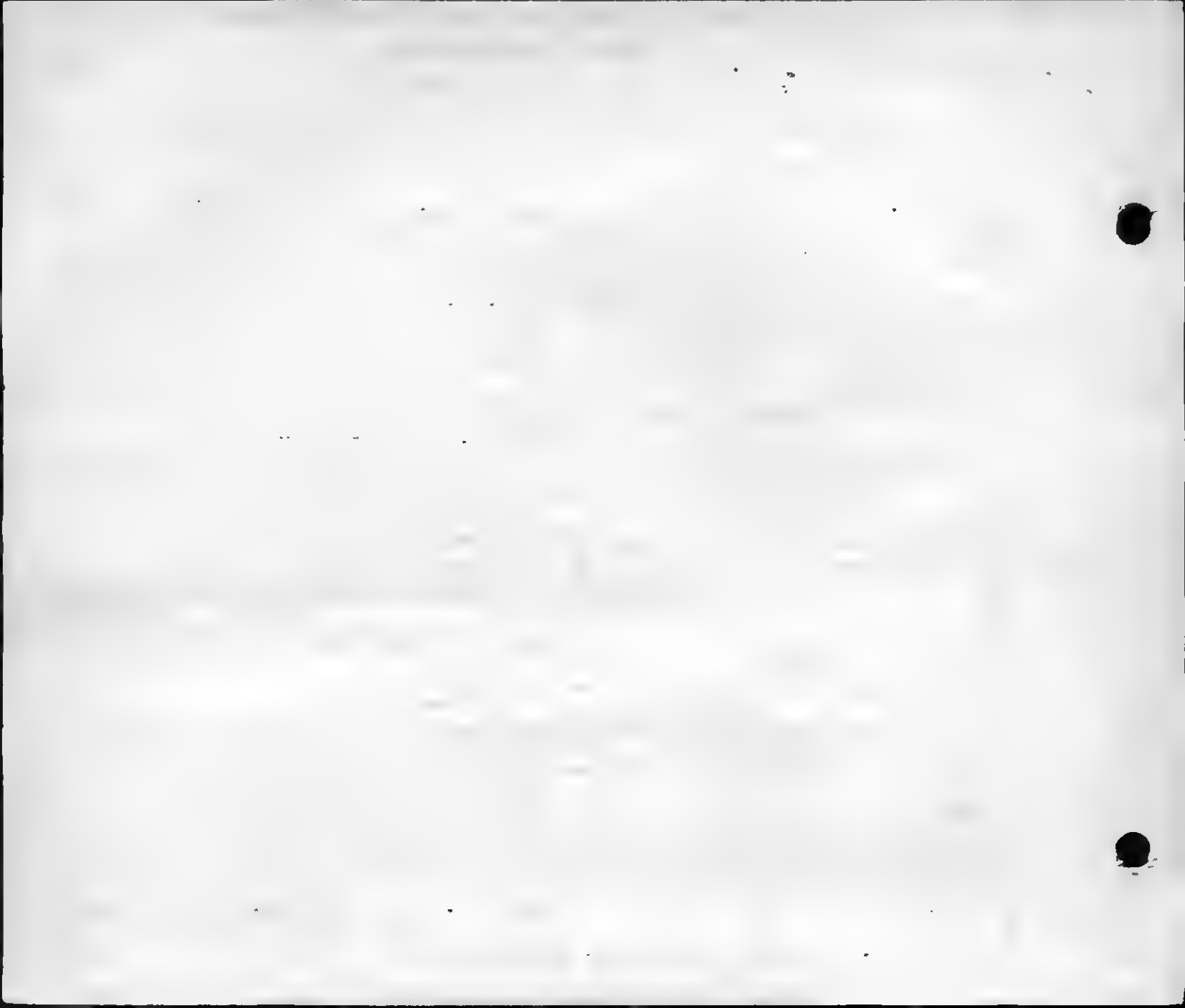
Reg. Dist. No.

05733

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived (If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3218 E. Thornapple Street</b>				d. STREET ADDRESS <b>3218 E. Thornapple Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>A</b> Last <b>Bright</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 5, 1891</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR: Months <b>3</b> Days <b>17</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS: Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chemistry</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Layman Bright</b>				14. MOTHER'S MAIDEN NAME <b>Emma Madora</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Lynne A. Bright-wife-same 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>Valvular heart disease</b> (b) <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>15-30 min</b> <b>9 months</b> <b>congenital</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	Month <b></b> Day <b></b> Year <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>Dec 50</b> , 19 <b>50</b> , to <b>22 May</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>15 May</b> , 19 <b>61</b> , and that death occurred at <b>11:30</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5029 BETHESDA AVE</b> DATE SIGNED <b>22 May 61</b>							
ACTUAL SIGNATURE <b>Herbert Martyn Jr</b> M.D. <b>Bethesda Md</b>							
PHYSICIAN'S NAME (Type) <b>HERBERT MARTYN JR Bethesda Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/24/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Charles Evans Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Reading, Pennsylvania</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>William L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 65731

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>Capitol Hill</u>	
3. NAME OF DECEASED (Type or print) <u>Wilbur Eugene Bright</u>		4. DATE OF DEATH <u>May 21 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/61</u>
9. AGE (In years lost birthday) yrs. <u>1</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILBUR EUGENE BRIGHT</u>	14. MOTHER'S MAIDEN NAME <u>SHIRLEY LYLES</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO <u>—</u>	17. INFORMANT <u>—</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Placental abruption</u> DUE TO <u>J.S.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Immaturity</u> DUE TO (c) <u>Twin Pregnancy</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/21</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>61</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Francis Brown</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laytonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Browne</u> ADDRESS <u>Rockville, Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>5/29</u>	24b. REG STRAR'S SIGNATURE <u>Robert L. Browne</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





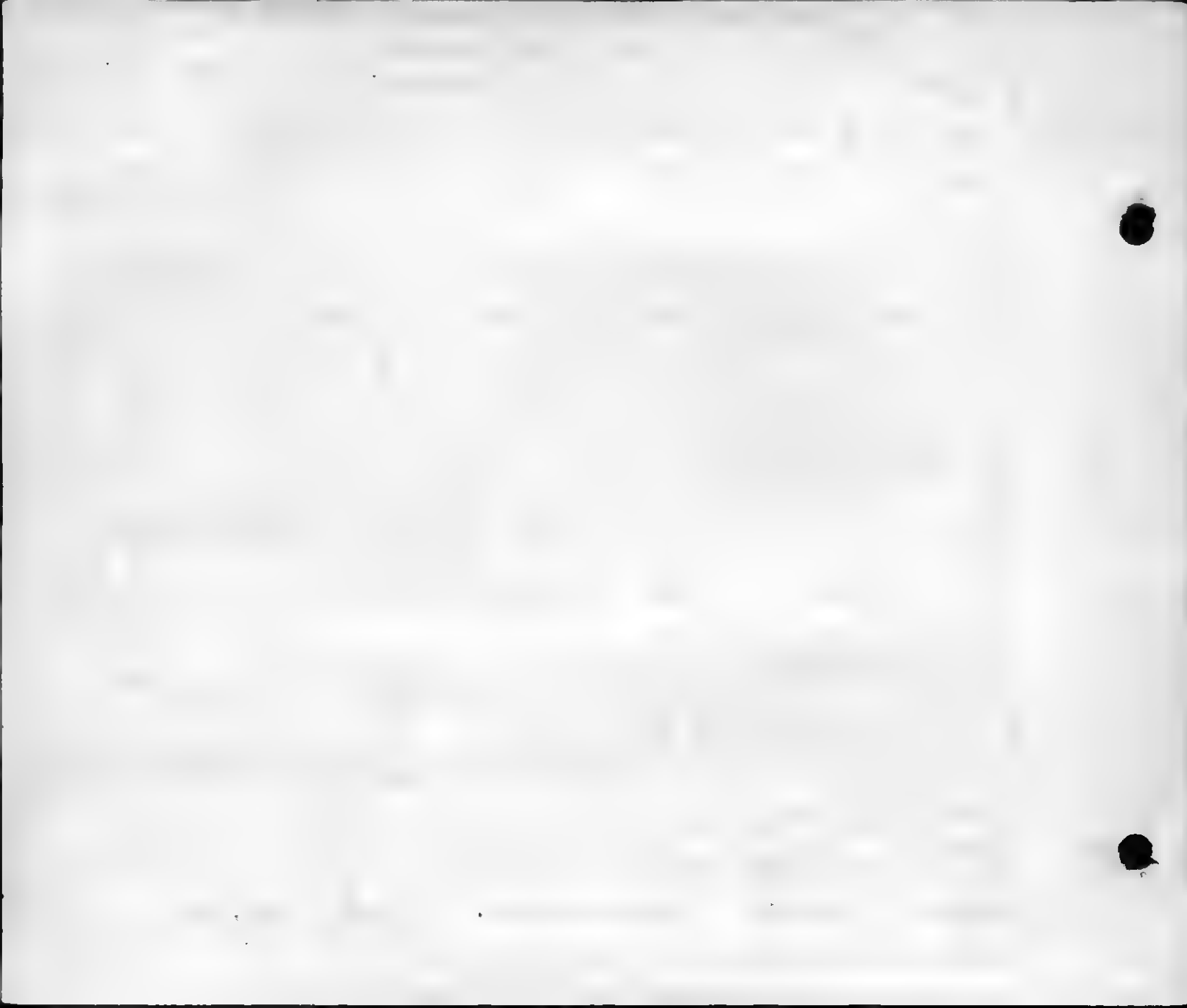
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **05735**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Indian Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> d. STREET ADDRESS <u>30 Baytonville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Wilma</u> First <u>Marria</u> Last <u>BRIGHT</u>				<b>4. DATE OF DEATH</b> <u>May 21</u> 19 <u>61</u> Month Day Year											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 21, 1961</u>		<b>9. AGE</b> (In years last birthday) <u>10</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>10</u> Days <u>15</u>		<b>11. IF UNDER 24 HRS</b> Hours <u>10</u> Min. <u>15</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>—</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>—</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Wilbur Eugene Bright</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Shirley — Lykes</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				<b>16. SOCIAL SECURITY NO</b> <u>—</u>		<b>17. INFORMANT</b> <u>MOTHER</u> Address <u>—</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atalectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic</u> DUE TO (c) <u>Joan Prognosis</u>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>5/21</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5/21</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED															
<b>ACTUAL SIGNATURE</b> <u>Robert L. Proctor</u> M.D.															
<b>PHYSICIAN'S NAME (Type)</b>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>5/24/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Brooke Grove Cem.</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Laytonville, Md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Proctor</u> ADDRESS <u>Reckville, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> DATE <u>MAY 29 '61</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

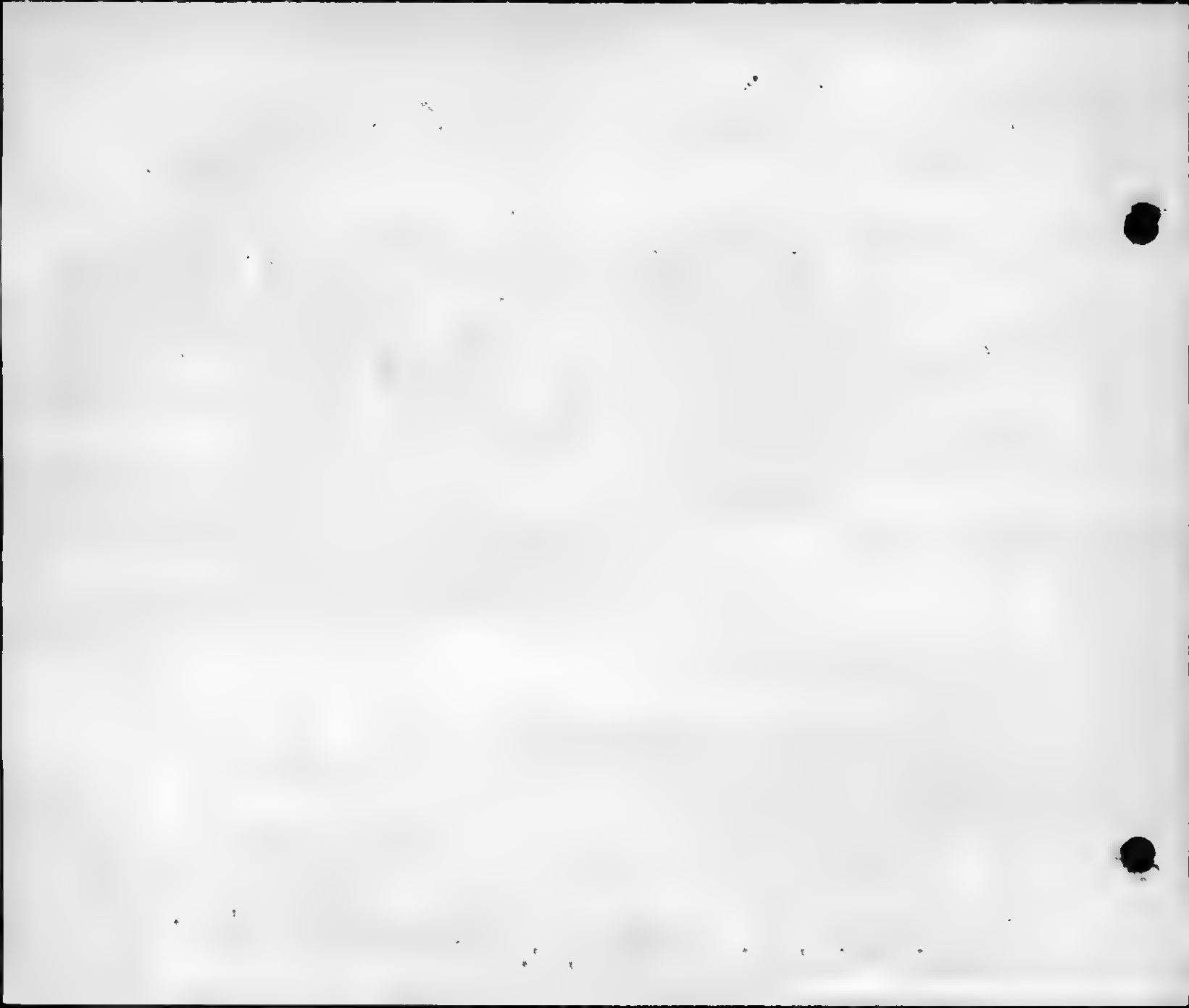
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5747

05736

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>District of Columbia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1400 Holly Street N.W.</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>1400 Holly Street N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susie (B) Broadhurst</u>		f. DATE OF DEATH <u>5 10 1961</u>	
5. SEX <u>Female</u>		7. MARIED <input type="checkbox"/> NEVER MARIED <input type="checkbox"/> D. VORCED <input type="checkbox"/>	
6. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>1-25-98-63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John Lindsay</u>		14. MOTHER'S MAIDEN NAME <u>Susie Boswell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SEC. A. SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital record</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>			
DUE TO (b) <u>Coronary occlusion</u>			
DUE TO (c) <u>Interruption of Heart Dec.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>December 1959</u> to <u>May 10, 1961</u> , that (I) <u>last</u> saw the deceased alive on <u>May 10, 1961</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B Arnold</u>			
22b. DATE SIGNED <u>—</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell B Arnold M.D.</u>			
22d. ADDRESS <u>8301 Cedar Hill Road, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>5/13/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Prince George's Co., Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>			
25a. REC'D BY REGISTRAR <u>MAY 16 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			



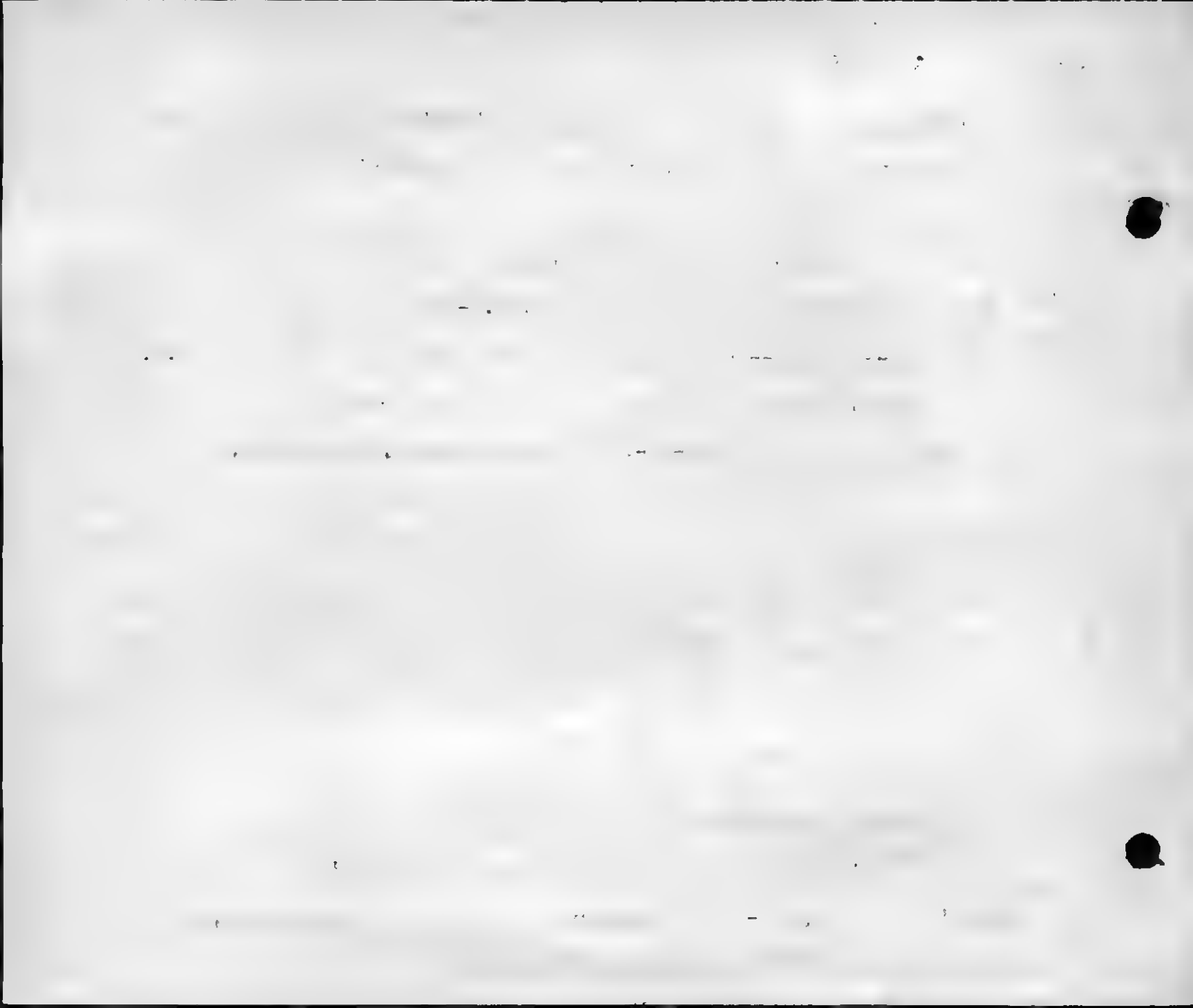
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5748  
CERTIFICATE OF DEATH  
05757

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b> c. LENGTH OF STAY IN 1b <b>71 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b> d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hatton Darby Brown</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>19 61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 2-1890</b>	
9. AGE (In years, last birthday) <b>71 yrs.</b>		10. F UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer---Owner---Active</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>	
13. FATHER'S NAME <b>Clifton Brown</b>		14. MOTHER'S MAIDEN NAME <b>Mary Darby</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>270-07-7642</b>	
17. INFORMANT <b>Richard Brown, Barnesville, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> 201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary arteriosclerosis</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>22 Apr. 1, 1961</b> to <b>26 May, 1961</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>23 May, 1961</b> , and that death occurred at <b>4:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Gordon M. Smith</b>		22b. DATE SIGNED <b>27 May 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		22d. ADDRESS <b>Barnesville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 29-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City, town or county) (State) <b>Beallsville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hillier</b>		25a. REC'D BY REGISTRAR <b>MAY 31 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hillier</b>		25c. REGISTRAR'S ADDRESS <b>Barnesville, Md</b>	



FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9 60

5748

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5738

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b life  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8009 Maple Ridge Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE md b. COUNTY Montg  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 8009 Maple Ridge Rd

3. NAME OF DECEASED (Type or print) William Harry Buchm  
4. DATE OF DEATH May 29 1961  
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 7-3-42  
9. AGE (In years last birthday) 18 yrs. IF UNDER 29 YEARS: Months 18 Days 18 IF UNDER 24 HRS.: Hours 18 Min. 18

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DC 10b. KIND OF BUSINESS OR INDUSTRY DC 11. BIRTHPLACE (State or foreign country) DC 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Graef W. Buchm 14. MOTHER'S MAIDEN NAME Vera Mangen  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 5-29-61 17. INFORMANT Vera Buchm (mother) Address Stu 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 237X DUE TO Brain Tumor (inoperable)  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)    DUE TO     
(c)    DUE TO     
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)    (b)    (c)   

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

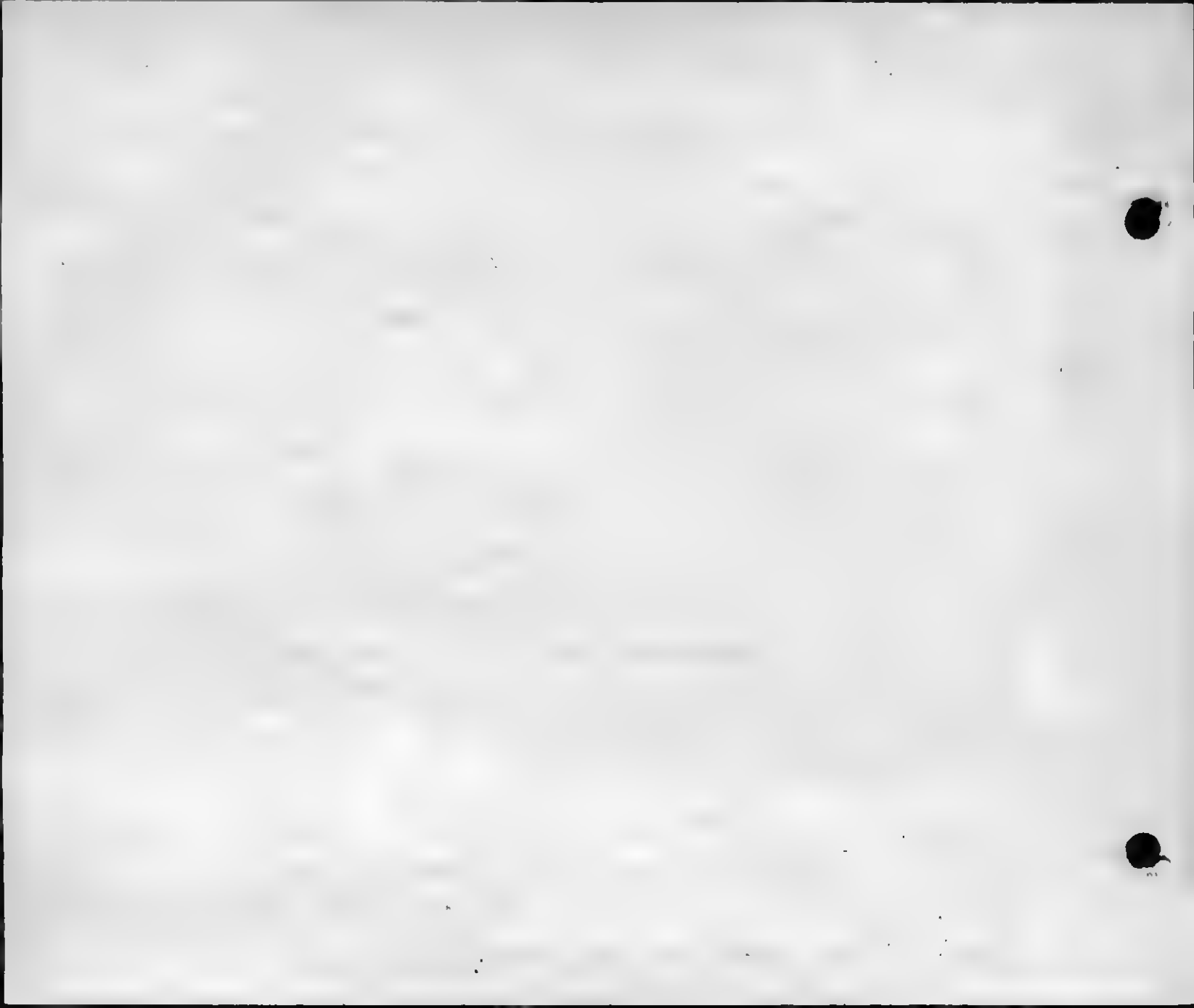
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19    20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)    20f. (City or town)    (County)    (State)   

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒  
Signature Frank J. Bluschart M.D. DATE SIGNED 5-29-61  
EXAMINER'S NAME (Type) FRANK J. BLUSCHART Address (Street, city, town, or county)   

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 5-31-61 22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY 22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.

23. FUNERAL DIRECTOR Francis Hollins ADDRESS 3821-14th St. N.W. Wash, D.C. 24a. REC'D BY REGISTRAR    24b. REGISTRAR'S SIGNATURE Arthur S. Hume DATE JUN 1 '61





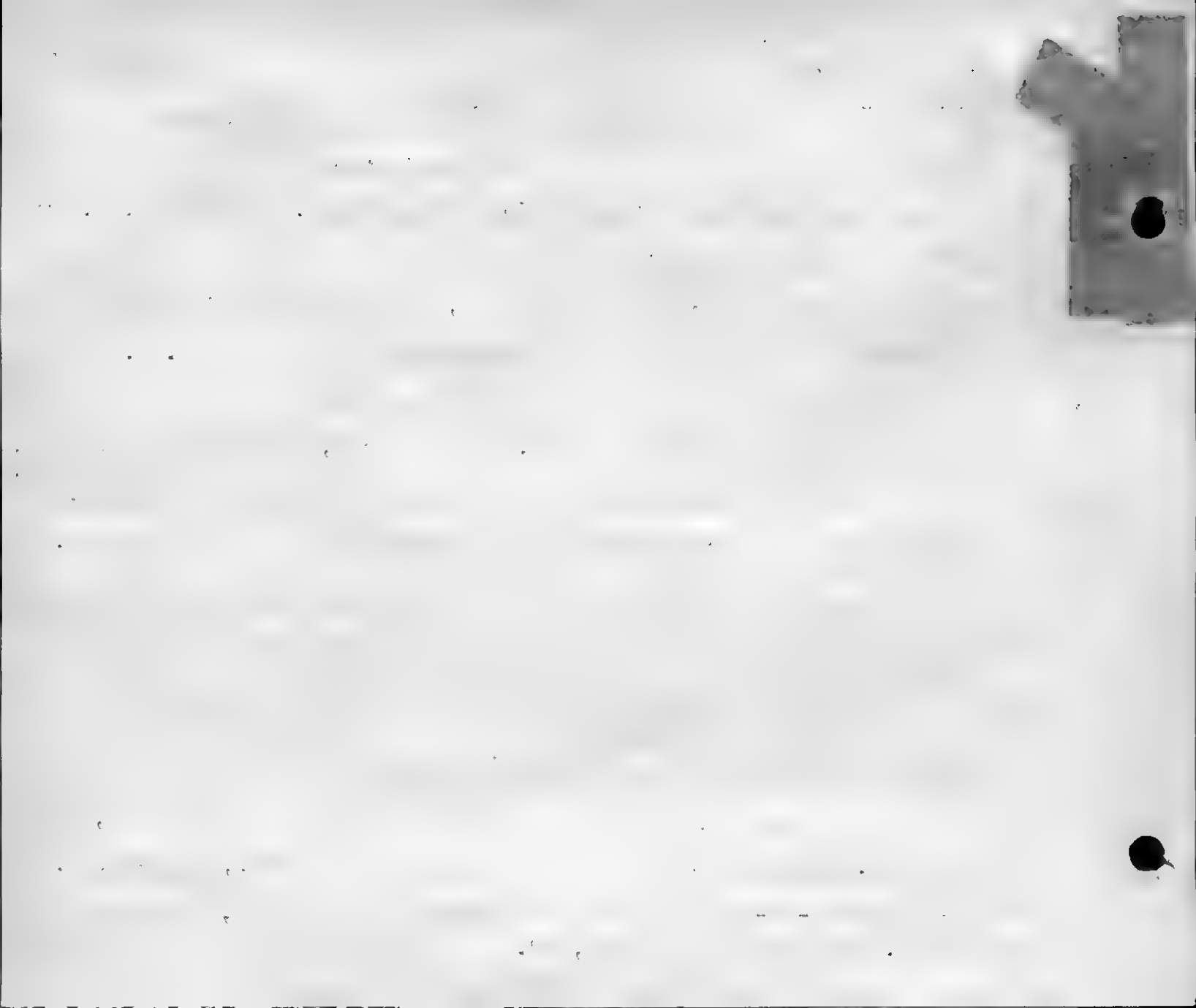
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove the permit to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5750 Item: Film G267 05739  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Has dance before admission) <b>Maryland</b> COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda 14</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kensington Gardens Sanitarium</b>		STREET ADDRESS <b>4037 Battery Lane 3300 McComas Ave., Kensington, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Ada Kirk Buffington</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 9, 1878</b>	
9. AGE (In years, last birthday) <b>83</b> yrs. <b>3</b> months <b>3</b> days		10. IF UNDER 1 YEAR Hours <b>1</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Josiah Kirk</b>		14. MOTHER'S MAIDEN NAME <b>Anne Reynolds</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Donald Dudley</b>		Address <b>4857 Battery La., Beth. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Arteriosclerosis</b> [a], stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b> <b>10 yrs.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1, 1961</b> to <b>May 12, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 12, 1961</b> , and that death occurred at <b>7:20 PM</b> from the causes and on the date stated above.		22b. DATE SIGNED <b>May 13, 1961</b>	
22a. SIGNATURE <b>Dr. Joseph Kenrick</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Joseph Kenrick</b>	
22d. ADDRESS <b>6450 Wisconsin Ave., Bethesda, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial-transit 5-15-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Brook View Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rising Sun, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>MAY 18 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Riddle</b>		25c. DATE	

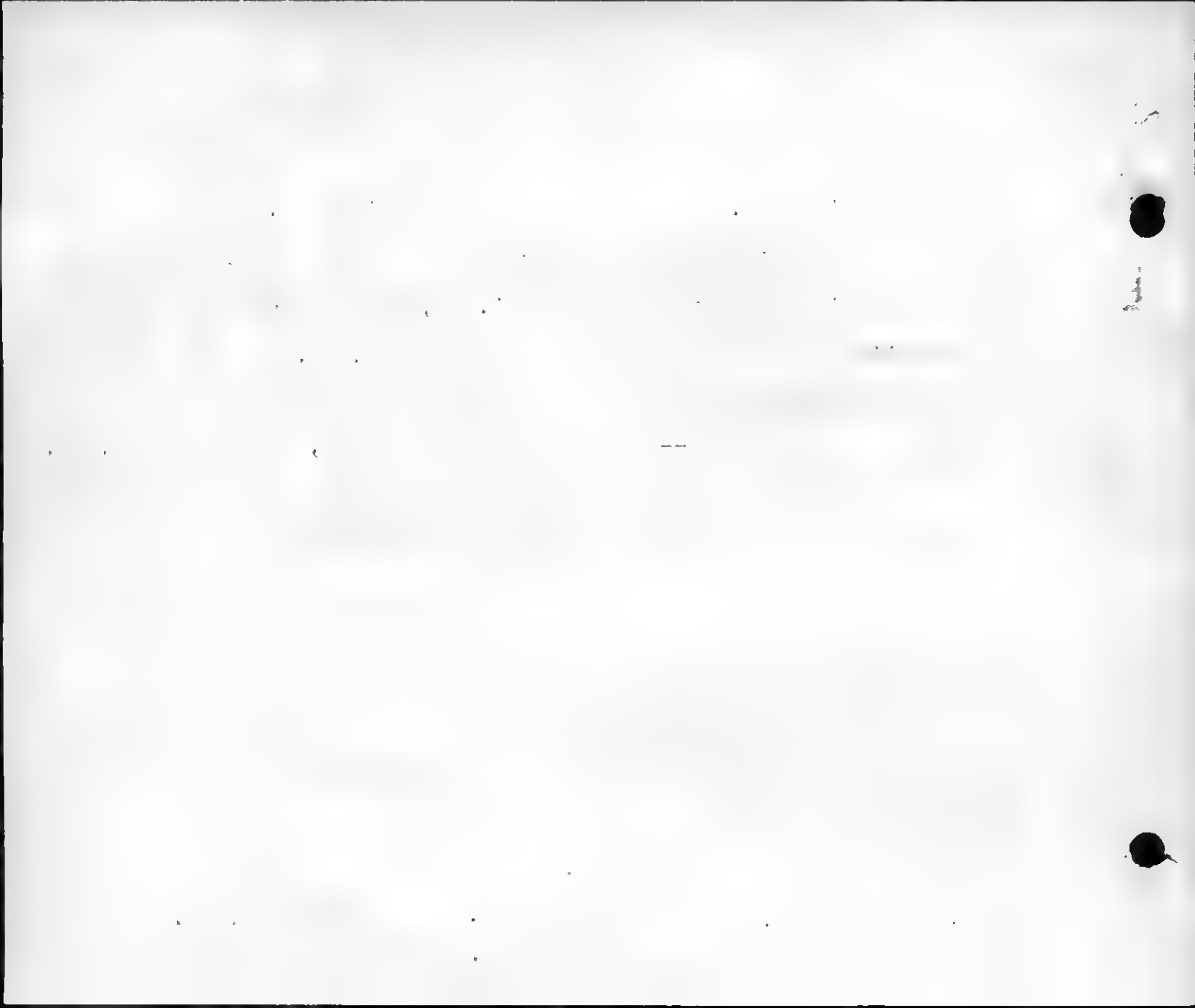


## CERTIFICATE OF DEATH

Reg. Dist. No. 05740

5751

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>26720 Ridge Rd.</b>				d. STREET ADDRESS <b>26720 Ridge Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Lolita</b> Middle <b>Young</b> Last <b>Burdette</b>				4. DATE OF DEATH Month <b>May</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 28, 1880</b>		9. AGE (In years last birthday) <b>80</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Damascus, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Dallas Young</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Etchison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		INFORMANT Address <b>Mrs James Kent Day Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion, acute, recurrent</b> 2001 DUE TO <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>20 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus; cerebro-vascular accidents, multiple</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>55</b> to <b>May 9</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>May 9</b> , 19 <b>61</b> , and that death occurred at <b>12:53 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main Street</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>Gilcin F. Leaders, M.D.</b> PHYSICIAN'S NAME (Type) <b>Gilcin F. Leaders, M.D.</b> <b>Damascus, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 11, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Wolsunth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 12 '61</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

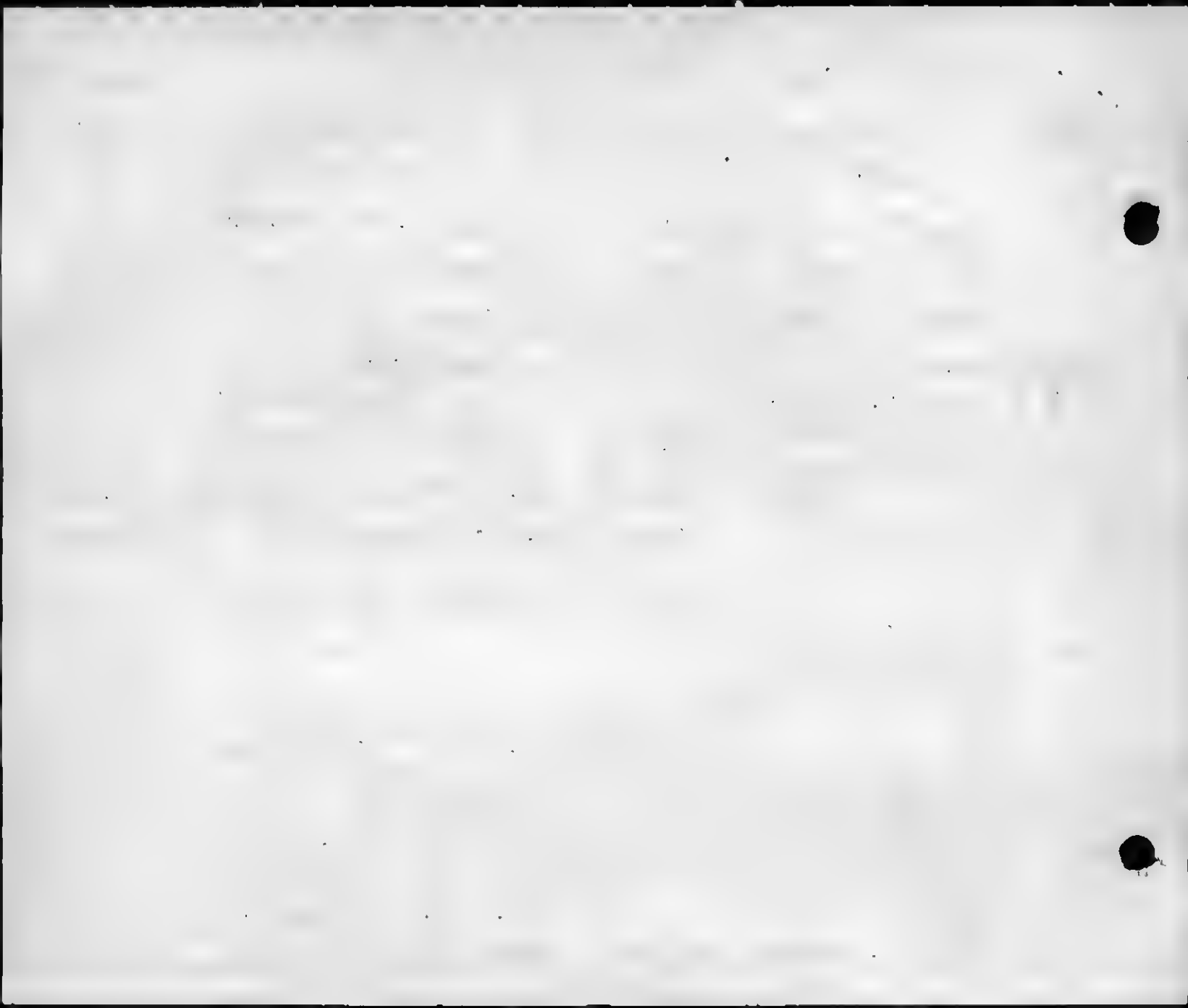
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05241

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN b. <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>615 W. Lynfield Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>615 W. Lynfield Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>BURTON</b> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARIED <input checked="" type="checkbox"/> NEVER MARIED <input type="checkbox"/> 8. DATE OF BIRTH <u>6/2/1925</u> 9. AGE (In years last birthday) <u>35</u> yrs. IF UNDER 1 YEAR: Months <u>27</u> Days <u>1961</u> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u> 11. BIRTHPLACE (County & State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John S. Grillo</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Olympia Pascal</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Richard Burton-Husband-same 2d</u> Address <u>2d</u>					
<b>18. CAUSE OF DEATH</b> (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC AND PULMONARY METASTASES</u> (b) <u>CARCINOMA OF BREAST</u> (c) <u>28 MOS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>28 MOS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>9:15A</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>7720 WISCONSIN AVE BETHESDA, MD.</u> <b>20f. (City or town)</b> <u>Bethesda</u> (County) <u>MD</u> (State) <u>MD</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>AUGUST 19, 60</u> <b>to</b> <u>MAY 27, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>MAY 27, 1961</u> , <b>and that death occurred at</b> <u>9:15A</u> , <b>from the causes and on the date stated above</b> <b>22a. SIGNATURE</b> <u>[Signature]</u> <b>22b. DATE SIGNED</b> <u>5/27/61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JOHN H. TUNNY, M.D.</u> <b>22d. ADDRESS</b> <u>7720 WISCONSIN AVE BETHESDA, MD.</u> <b>22e. REC'D BY REGISTRAR</b> <u>[Signature]</u> <b>22f. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>5/31/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat. Cem.</u> <b>23d. LOCATION (City, town or county)</b> <u>Arlington, Virginia</u> (State) <u>VA</u> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>[Signature]</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> <b>DATE</b> <u>MAY 31 '61</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5753

65742

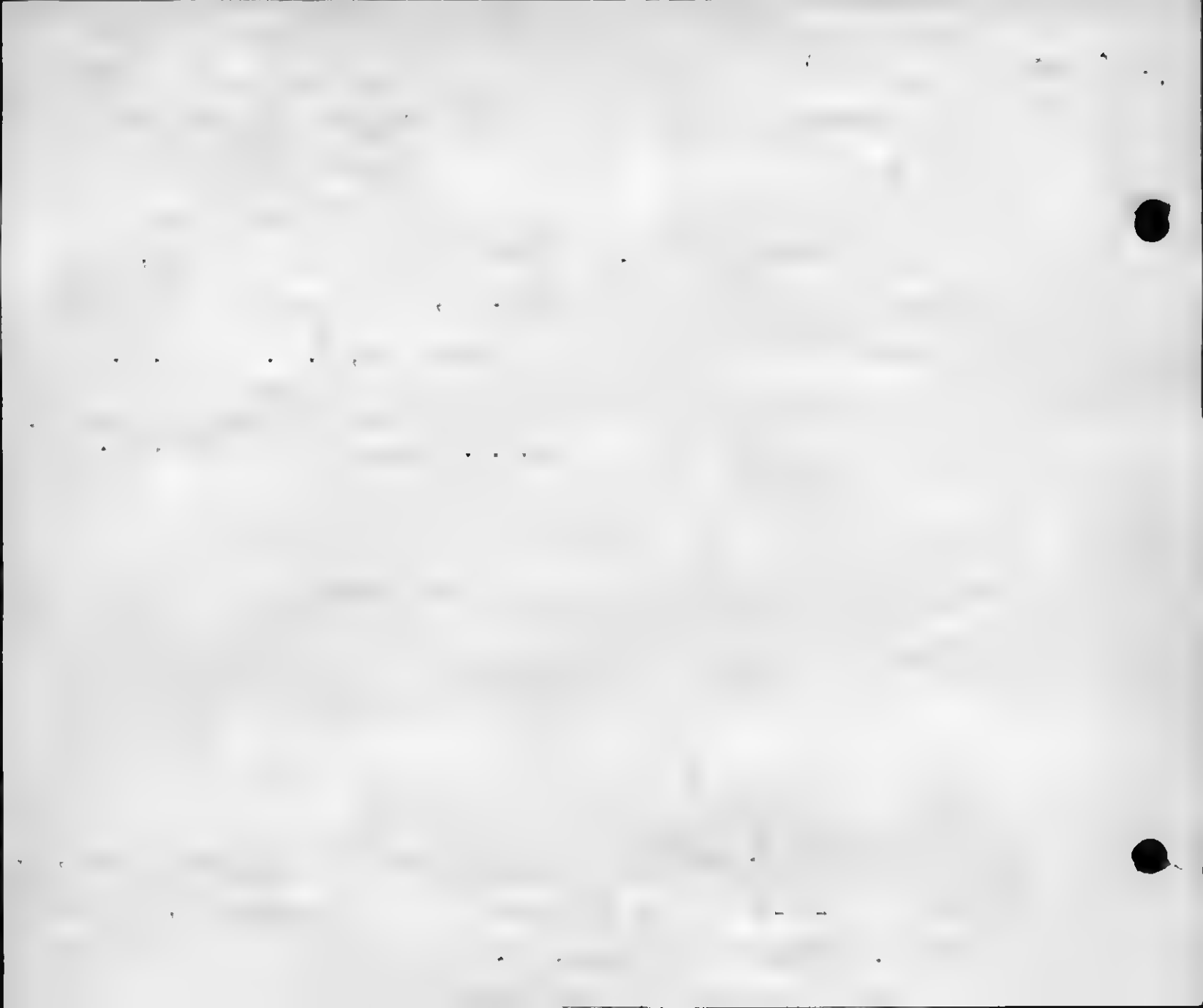
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>8018 Park Lane</b>		d. STREET ADDRESS <b>8018 Park Lane</b>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH R. CANADA</b>		4. DATE OF DEATH <b>May 12, 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 26, 1897</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR <b>Months</b> <b>Days</b> <b>Hours</b> <b>Min.</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>George Donaldson</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Hickey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter Mrs. D.A. Pampillonia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>CARDIAC Failure.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Myocardial Infarct</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>-</b>	
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year <b>May 9, 1961</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Silver Spring, Maryland</b>		20g. (County) <b>Montgomery</b>	
20h. (State) <b>Md.</b>		21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1960</b> to <b>Present</b> , that (I) (we) last saw the deceased alive on <b>May 9, 1961</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Donald Q. Ekman</b>		22b. DATE SIGNED <b>5/12/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DONALD Q. EKMAN</b>		22d. ADDRESS <b>5707 Wisconsin Ave, Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-15-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town or county) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		25c. ADDRESS <b>Bethesda, Md.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

13  
FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5754

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park  
c. LENGTH OF STAY IN 1b 24 yrs  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4419 Strathmore Ave

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE md b. COUNTY mntg  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park  
d. STREET ADDRESS 4419 Strathmore Ave  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Leslie Maynard Cannon  
4. DATE OF DEATH May 26 1961  
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-14-91 9. AGE (In years last birthday) 70 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY N.C. 11. BIRTHPLACE (State or foreign country) N.C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME (Unknown) King 14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 579-01-3233 17. INFORMANT Guilford Cannon (husband) Address Stun 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary occlusion  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease  
DUE TO (c) 54 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) History of previous coronary disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

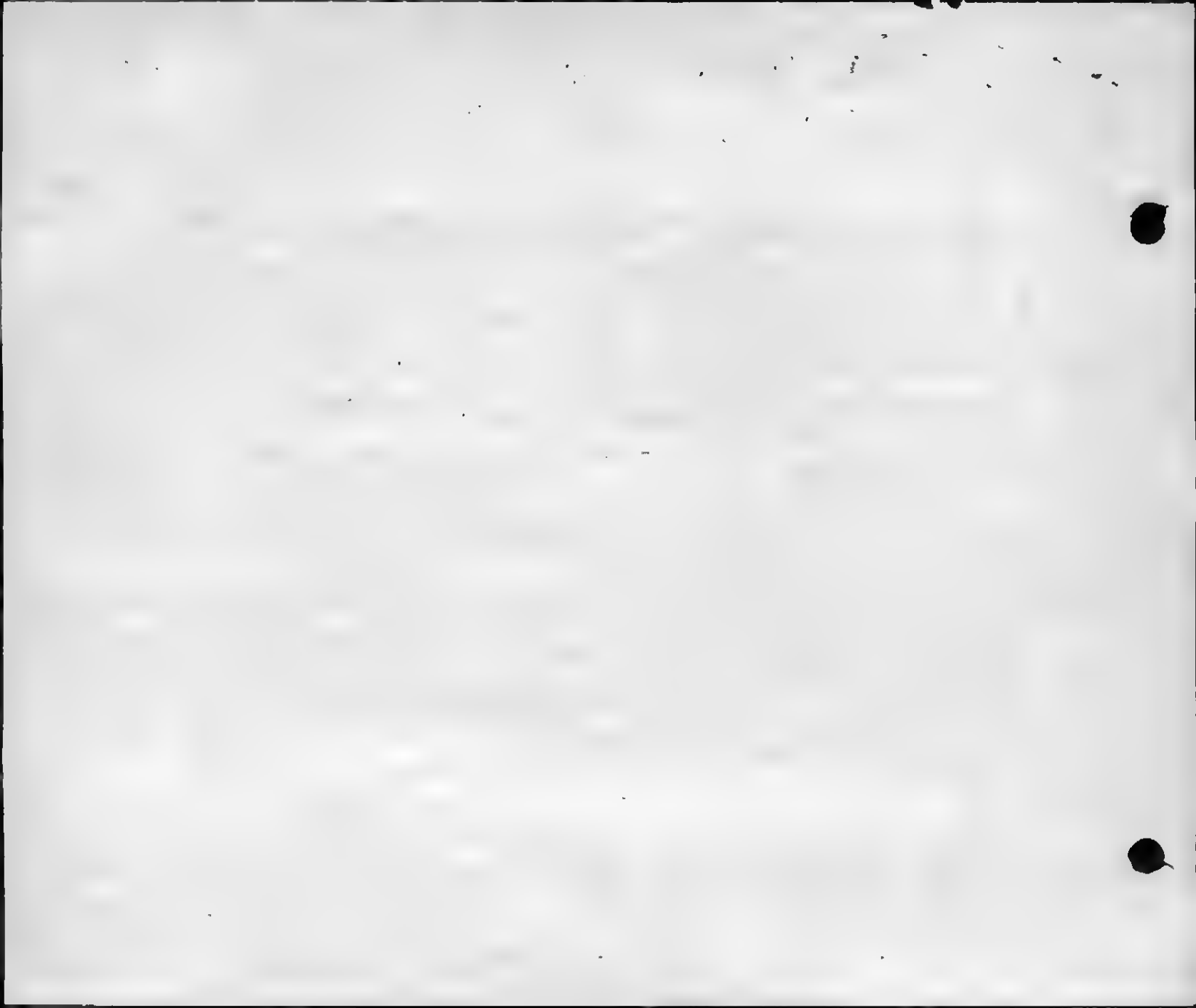
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hyattsville, Maryland (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Broschant ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 5-26-61  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION REMOVAL (Specify) Burial 22b. DATE THEREOF 5/29/61 22c. NAME OF CEMETERY OR CREMATORY George Wash. Cemetery 22d. LOCATION (City, town, or country) (State) Hyattsville, Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR MAY 31 '61 24b. REGISTRAR'S SIGNATURE A. L. L. Harris



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

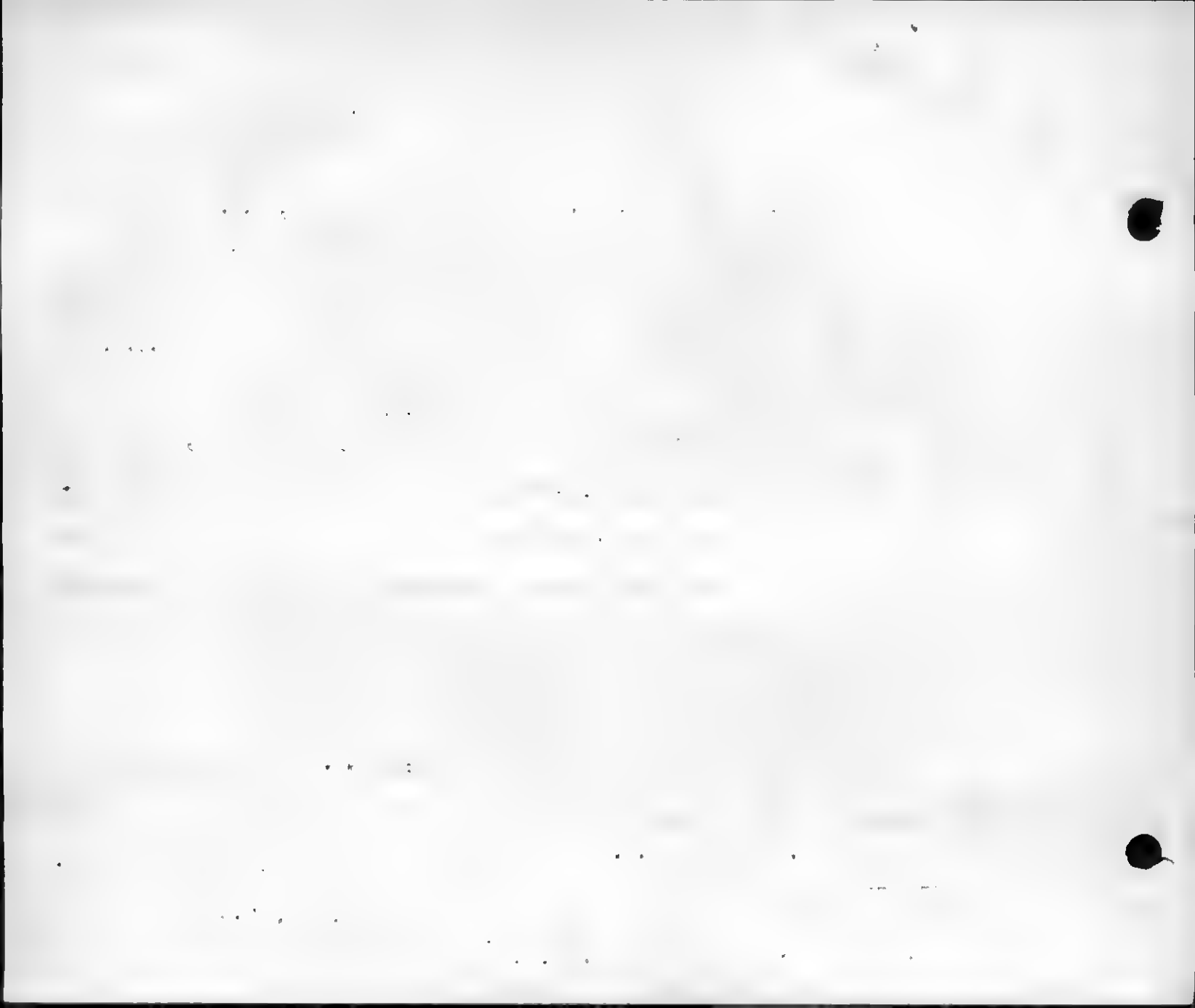
5755

65744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>156 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1420 Saratoga Avenue, N.E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Arthur</b> Last <b>Carson</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 3, 1904</b>		9. AGE (In years as of birthday) <b>57</b> yrs	10. IF UNDER 1 YEAR Months <b>24</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur Carson</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Gregg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-07-9202</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Congestion</b> <b>141.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <b>Metastatic Carcinoma</b> DUE TO (c) <b>Epidermoid carcinoma of tongue</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>3 weeks</b> <b>10 months</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 19, 1960</b> to <b>May 21, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 24, 1961</b> , and that death occurred at <b>9:55 p.m.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>David T. Crawford M.D.</b>				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID T. CRAWFORD, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/27/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.,</b>				ADDRESS <b>Wash, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 29 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

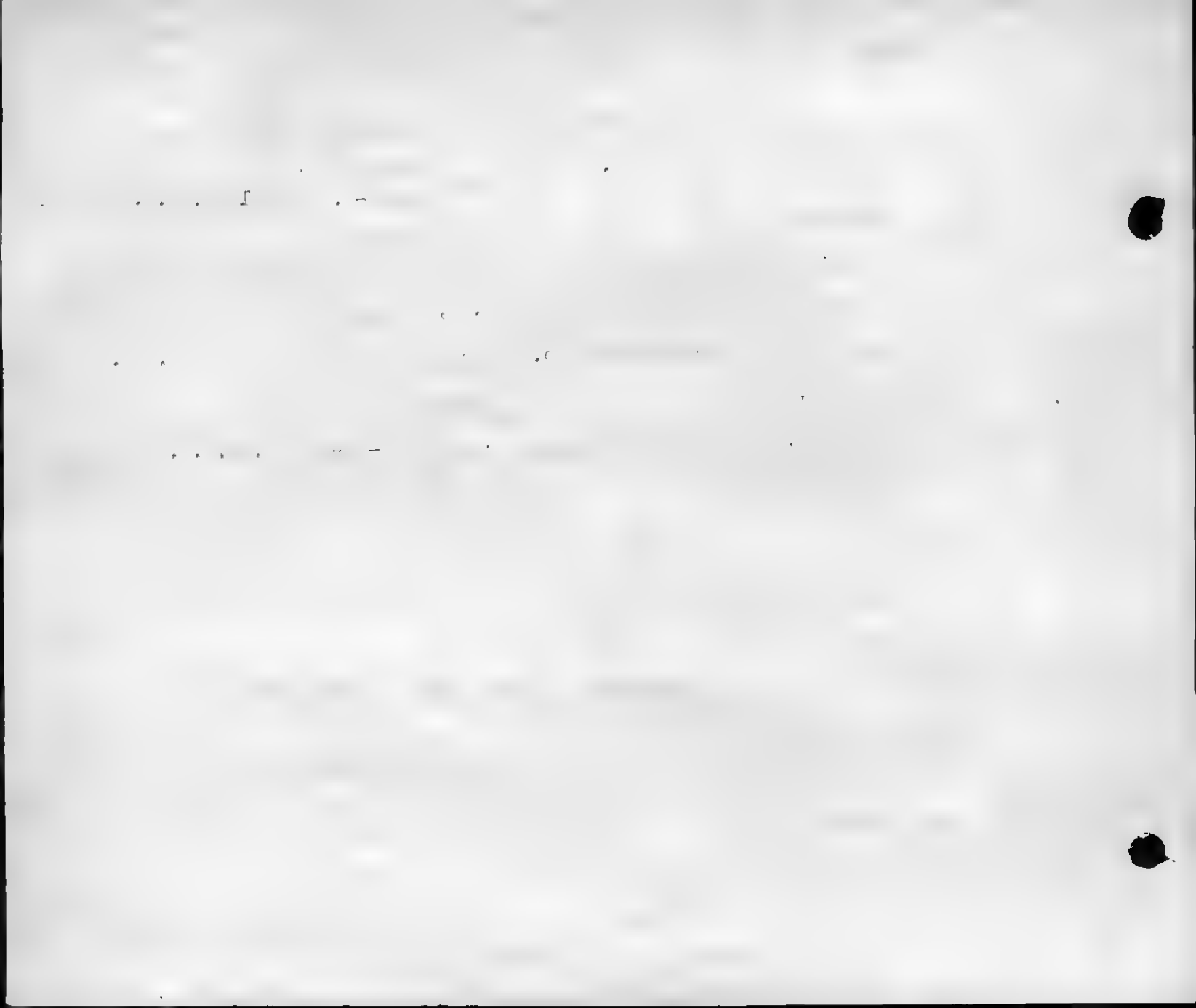
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY in 1b <u>3hrs.</u>		d. STREET ADDRESS <u>1341-E. Capitol St. S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>Herman Joseph Carter</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>May 19 1961</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 8, 1915</u>
9. AGE (In years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Awning Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Burton Awning Co. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leighton Carter</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>Yes World War 2</u>		16. SOCIAL SECURITY NO. <u>577-05-2102</u>	
17. INFORMANT <u>Marjorie Carter-11-35 th. St. S.E.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>fracture of skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from ladder 24 ft while placing awnings</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:34 p.m. 5-19 1961</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building</u>	
20e. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20f. (City or town) <u>Cherry Chase Monty Md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>5-23-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>		22d. LOCATION (City, town, or country) <u>Long by river, Va</u> (State)	
23. FUNERAL DIRECTOR <u>Robert A Mattingly</u>		24a. REC'D BY REGISTRAR <u>Wash DC</u> 24b. REGISTRAR'S SIGNATURE <u>Robert A. Mattingly</u>	
ADDRESS <u>131-11 St SE</u>		DATE <u>MAY 22 '61</u>	



may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

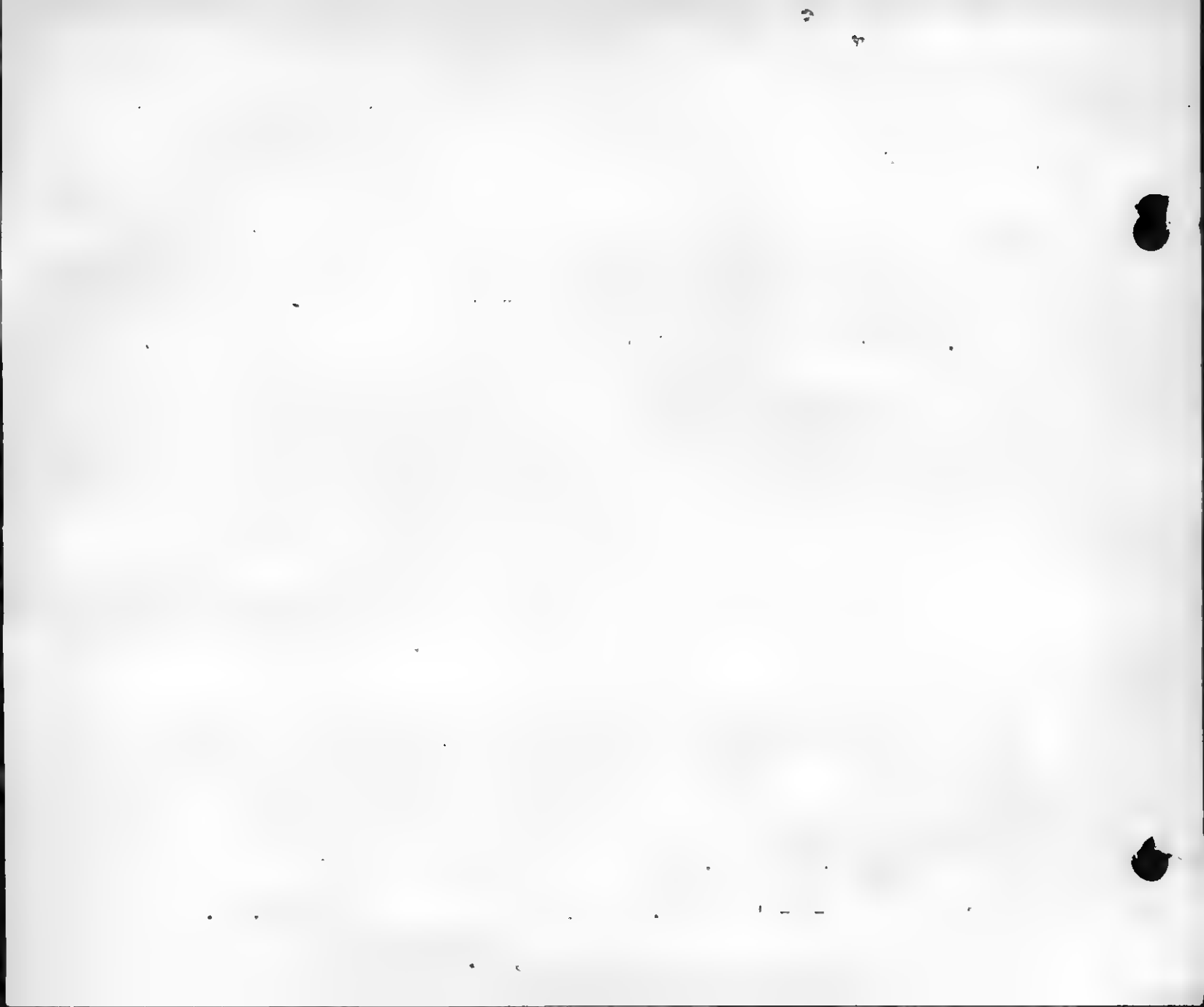
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5757

05746

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <span style="float:right">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float:right">b. COUNTY <b>MONTGOMERY</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>13 DAYS</b>			CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKEVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>(SUNSHINE)</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MONTGOMERY</b> Middle <b>WRIGHT</b> Last <b>CASHELL</b>				<b>4. DATE OF DEATH</b> Month <b>MAY</b> Day <b>19</b> Year <b>19 61</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2-15-1876</b>	
<b>9. AGE</b> (in years lost birthday) <b>85</b> yrs		<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>GEORGE WASHINGTON CASHELL</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>CATHERINE AUGUSTA HOBBS</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <span style="float:right">Address</span> <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Mesenteric Thrombosis</b> <b>570.2</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 wks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis.</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 ____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>5/5/61</b> <b>19</b> to <b>5/19</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>5/17</b> <b>1961</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Richard A. Yates</b>				<b>22b. DATE SIGNED</b> <b>5/19/61</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>R. A. YATES, M. D.</b>				<b>22d. ADDRESS</b> <b>OLNEY, MARYLAND</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5-22-61</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Carmel</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Sunshine, Md.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis H. Barber</b>				<b>ADDRESS</b> <b>Laytonsville, Md.</b>		<b>25a. REC'D BY REG STRAR</b> <b>MAY 25 '61</b>	
				<b>25b. REGISTRAR'S SIGNATURE</b> <b>William S. Houch</b>			





5758

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

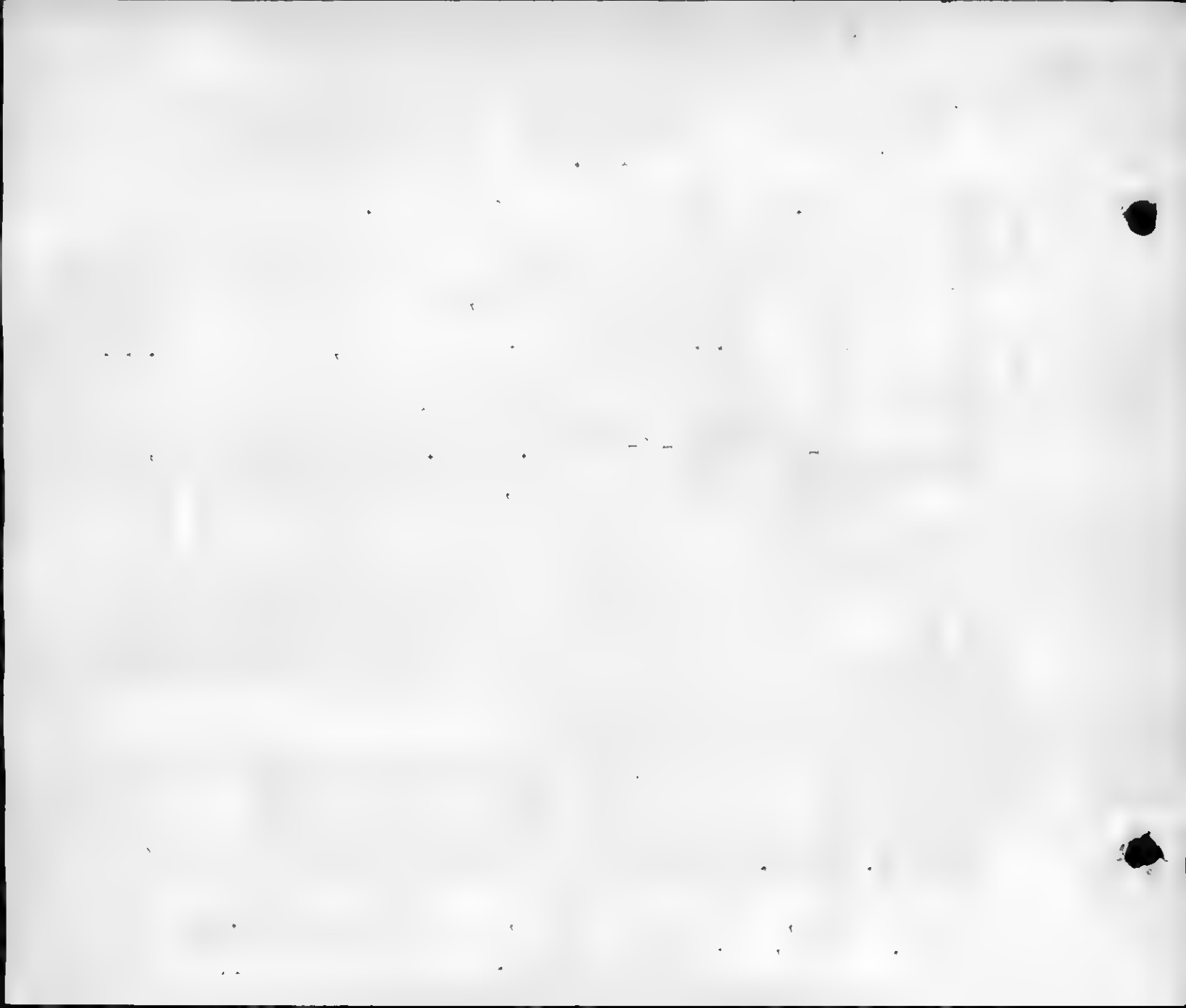
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05747

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN 1b <b>1 Hr.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4939 Cordell Ave.</b>		2. USUAL RESIDENCE (Where deceased lived If not in an Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>929 GIST AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ferdinand P Cayelli</b>		4. DATE OF DEATH <b>MAY 11 19 61</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1905</b>	
9. AGE (In years (not to 10 days)) <b>56</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania, Mason Town</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Daniel Cayelli Italy</b>		14. MOTHER'S MAIDEN NAME <b>Eletta Archangeli Italy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-6779</b>		17. INFORMANT <b>929 Gist Avenue Mrs. Nell R. Cayellie Silver Spring, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, sudden</b> DUE TO (b) <b>7201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>DUE TO</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous Heart Disease</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>5/11/61</b>	
EXAMINER'S NAME (Type) <b>Dr. Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gate Of Heaven, Cemetery Montgomery Co. Maryland</b>	
22d. LOCATION (City, town, or county) (State)		24a. REC'D BY REGISTRAR <b>Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton L. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

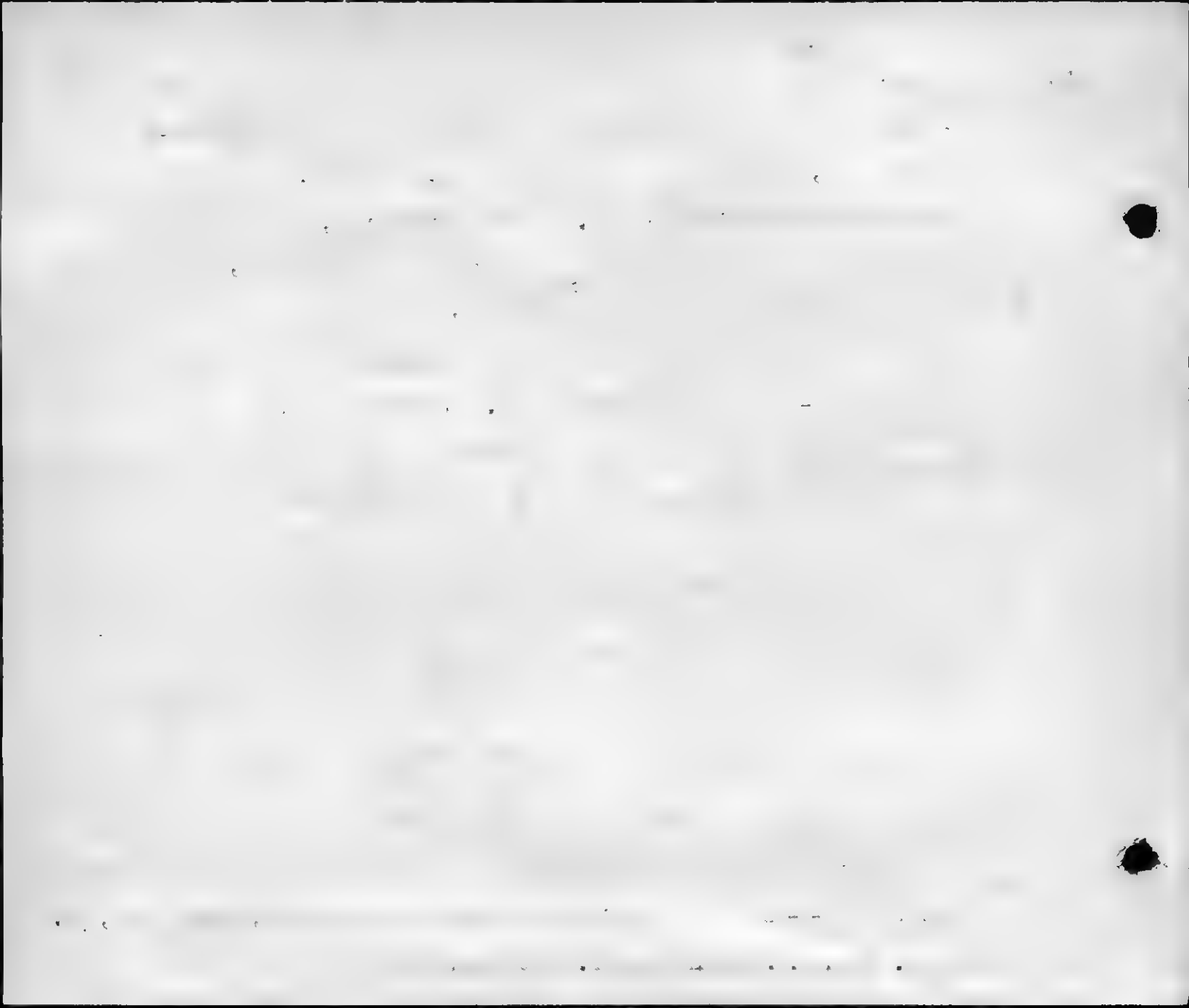
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MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
5755			
05748			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>8504 16th Street,</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Takoma Park,</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Chaikin</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Male</b>		4. DATE OF DEATH <b>May 26,</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1961</b>	
9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Min. <b>19 0</b>		10. BIRTHPLACE (Country & State, or foreign country) <b>Maryland</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>George -</b>		14. MOTHER'S MAIDEN NAME <b>L. Judith Shapiro</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>father</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Subdural &amp; subarachnoid hemorrhage</b> 158.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Achondroplastic dwarfism</b> (a), stating the underlying cause last. (c) <b>Congenital</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 25, 1961</b> to <b>May 26, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 25, 1961</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Sydney Leventhal</b>		22b. DATE SIGNED <b>May 26, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M.D.</b>		22d. ADDRESS <b>9210 Colverville Rd., Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>6-3-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>		23d. LOCATION (City, town or county) (State) <b>Takoma Park, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M.D. Washington San. &amp; Hospital</b>		25a. REC'D BY REGISTRAR <b>DATE JUN 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>			

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5760

## CERTIFICATE OF DEATH

Reg. Dist. No.

05740

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>Marvella</b> Last <b>Childs</b>		4. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1881</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Aden Allnutt</b>		14. MOTHER'S MAIDEN NAME <b>Martha Duvall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mrs. William Childs</b>		Address <b>Derwood, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>6000</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular brain</b> (c) <b>Chronic Pyelonephritis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>Yes</b> <b>Yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>5/3</b> , <b>1961</b> , that I last saw the deceased alive on <b>4/29</b> <b>1961</b> , and that death occurred at <b>2:35 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>C. H. Ligon, M.D.</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>C. H. Ligon, M.D.</b>		Medical Center, Sandy Spring, Md. <b>5/3/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-5-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John</b>	22d. LOCATION (City, town, or county) (State) <b>Olney, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samie H. Barber</b>		ADDRESS <b>Laytonville, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5761

## CERTIFICATE OF DEATH

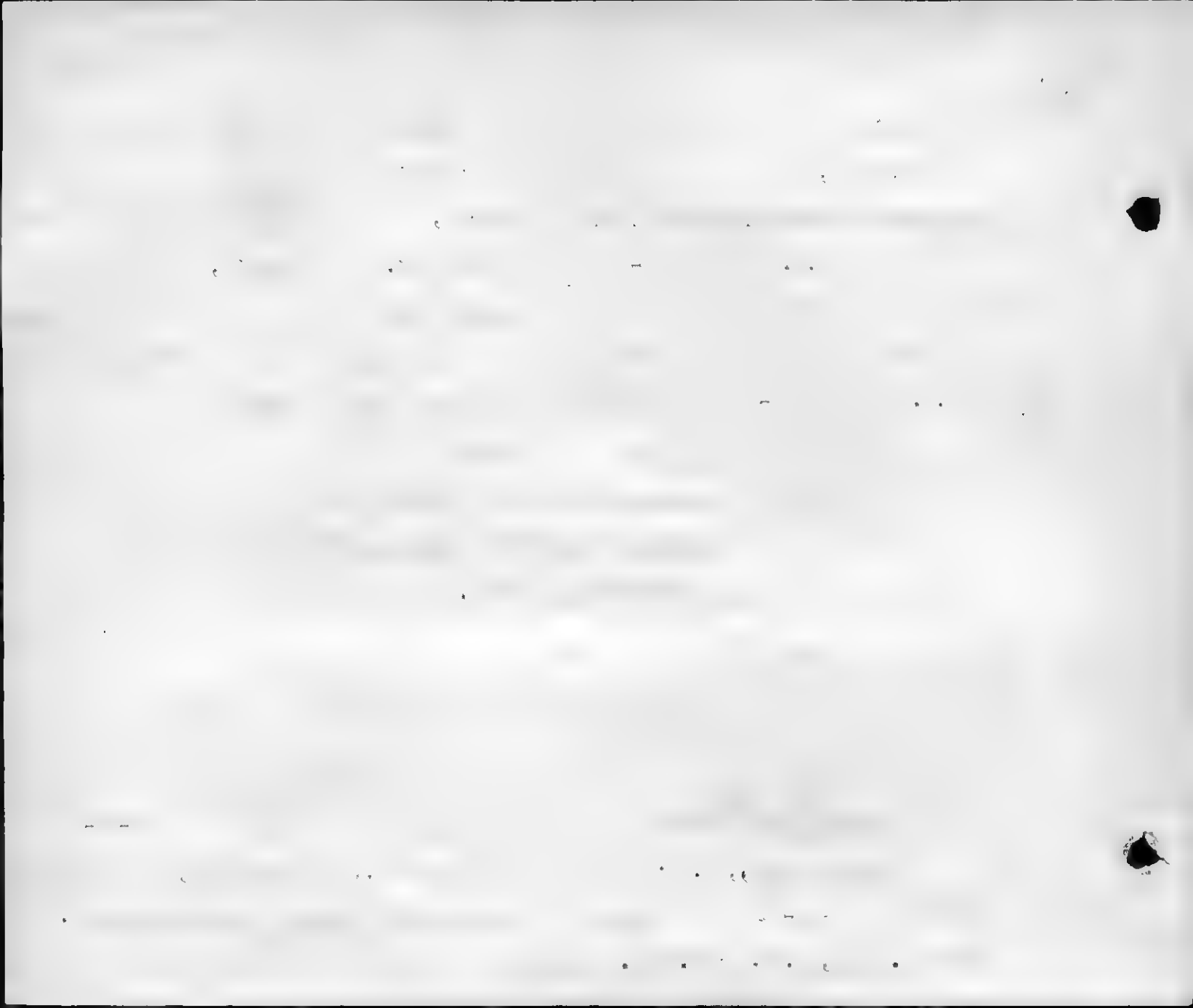
C6896

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park,</u> c. LENGTH OF STAY IN b. <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission only) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Jessup</u> d. STREET ADDRESS <u>Box 6,</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>L.C.</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>May 28,</u> 19 <u>61</u> Month Day Year		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 28, 1961</u>			
<b>9. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>		<b>13. FATHER'S NAME</b> <u>L.C.</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>Peggy Ann Meade</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>					
<b>16. SOCIAL SECURITY NO</b> <u>no</u>		<b>17. INFORMANT</b> <u>father</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis and emphysema</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Microscopic pulmonary pathology suspected.</u> (c) <u>(Microscopics to follow.)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Donald Straus</u>		<b>22b. DATE SIGNED</b> <u>5-28-61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Donald Straus, M. D.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>5-29-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Hare, M. D. Wash. San. &amp; Hospital</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JUN 13 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hare</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5762

457511

**1. PLACE OF DEATH**  
a. COUNTY

**MONTGOMERY**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**Takoma Park**

**MARYLAND**  
c. LENGTH OF STAY IN 1b  
**10 days**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
**Washington Sanitarium and Hospital**

**2. USUAL RESIDENCE** (Where deceased lived, If institution; Residence before admission)  
e. STATE  
**Maryland**  
f. COUNTY  
**Prince George**  
g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
**W. Hyattsville**

h. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

**3. NAME OF DECEASED**  
(Type or print)

**Michael Alexander Codirezzi**

**4. DATE OF DEATH**

Month **May** Day **6** Year **1961**

**5. SEX**

**M**

**6. COLOR OR RACE**

**W**

**7. MARRIED** ☒ **NEVER MARRIED** ☐  
**WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**

**9-12-15**

**9. AGE** (In years last birthday)

**45** yrs.

**10. UNDER 1 YEAR** **IF UNDER 24 HRS.**

Months **0** Days **0** Hours **0** Min. **0**

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired)

**Draftsman**

**10b. KIND OF BUSINESS OR INDUSTRY**

**D.C. Highway Dept.**

**11. BIRTHPLACE** (County & State, or foreign country)

**District of Columbia**

**12. CITIZEN OF WHAT COUNTRY?**

**U.S.**

**13. FATHER'S NAME**

**John Codirezzi**

**14. MOTHER'S MAIDEN NAME**

**Grace Murgia**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service)

**No**

**16. SOCIAL SECURITY NO.**

**unk.**

**17. INFORMANT**

**Hospital Records**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:**  
**IMMEDIATE CAUSE (a)**

**195.3** DUE TO **Compression BRAIN stem**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Cerebral oedema**  
DUE TO **Suprasellar neoplasia estimated 4 mos. +** (c)

**INTERVAL BETWEEN ONSET AND DEATH**  
**10 days**

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)**

**Suspected infarction left frontal lobe**

**19. WAS AUTOPSY PERFORMED?**  
YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (If either, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY**  
Month, Day, Year  
Hour a.m. **19** p.m.

**20d. INJURY OCCURRED**  
While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f. (City or town)**

**(County)**

**(State)**

**21. I certify that (I) (this hospital) attended the deceased from 4/25, 1961 to 5/6, 1961, that (I) (we) last saw the deceased alive on 5/5, 1961, and that death occurred on 5/6, 1961, from the causes and on the date stated above.**

**22a. SIGNATURE**  
**John T. Lord M.D.**  
**22c. PHYSICIAN'S NAME (Type)**  
**John T. LORD**

**22b. DATE SIGNED**  
**5/6/61**  
**22d. ADDRESS**  
**1015 Spring Street Silver Spring Md.**

**23a. BURIAL, CREMATION REMOVAL** (Specify)

**BURIAL**

**23b. DATE THEREOF**

**May 9, 1961**

**23c. NAME OF CEMETERY OR CREMATORY**

**GATE OF HEAVEN**

**23d. LOCATION** (City, town or county)

**Wheaton MD**

**24. FUNERAL DIRECTOR'S SIGNATURE**

**W. J. Cartmel**

**ADDRESS**

**3603 14th St NW**

**25a. REC'D BY REGISTRAR**

**MAY 8 '61**

**25b. REGISTRAR'S SIGNATURE**

**Arthur J. Thomas**

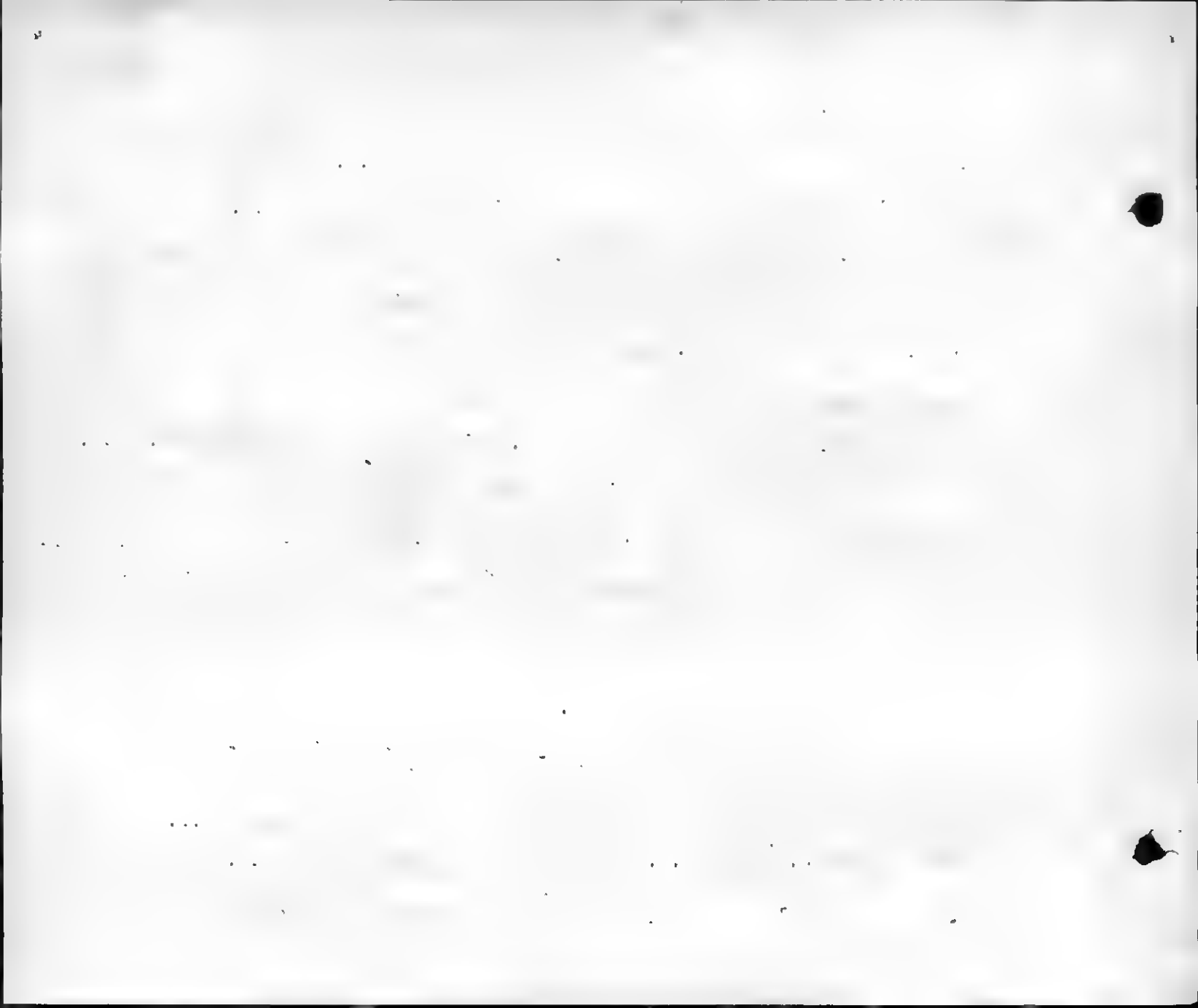
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



Reg. Dist. No. 1575

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5-29-61</b>	22c. NAME OF CEMETERY <del>OR CREMATORY</del> ... <b>ARLINGTON NATIONAL CEMETERY</b>	22d. LOCATION (City, town, or county) <b>ARLINGTON, VIRGINIA</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b>		ADDRESS <b>-3501 14th St., NW</b>	24a. REC'D BY REGISTRAR <b>DATE MAY 31 '61</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



TO DEP. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #43. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
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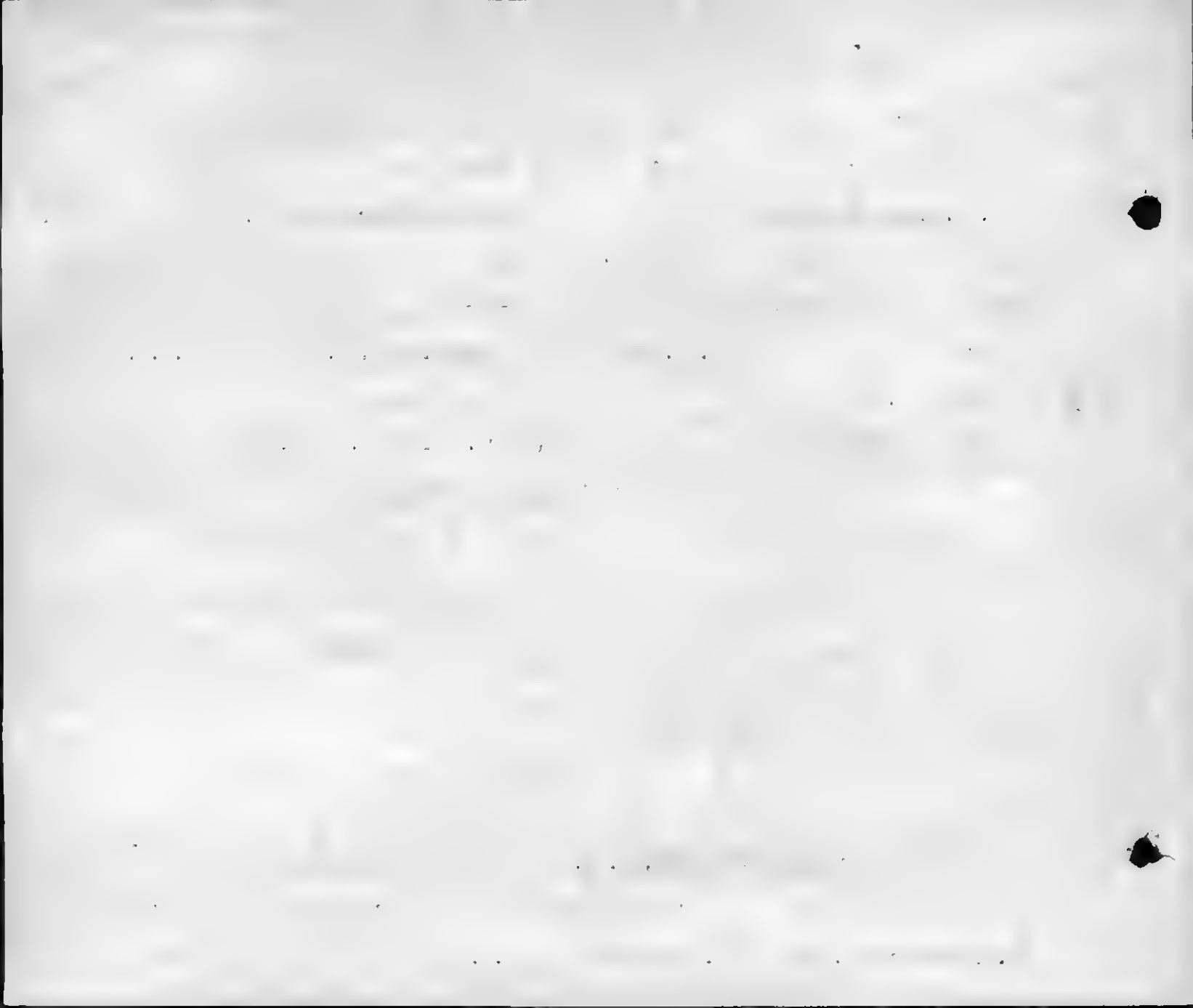
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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY (In days) <b>DOX</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4431 35th Street, N. W.</b>		d. STREET ADDRESS <b>4431 35th Street, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Earl Walter COOK</b>		4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-29-88</b>		9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Vincent R. COOK</b>		14. MOTHER'S MAIDEN NAME <b>Mollie BROWN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown; If yes, give year or dates of service) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>W( ) Mrs. Mertie I. Cook, same as #2 above</b>		17. INFORMANT <b>(W ) Mrs. Mertie I. Cook, same as #2 above</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>+20.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>120.0</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>120.0</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Frank J. Broschart</b>		EXAMINER'S NAME (Type) <b>Frank J. BROSCHEART, M. D.</b>		DATE SIGNED <b>5-29-61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-2-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington Virginia</b>		23. FUNERAL DIRECTOR <b>W.W. Chambers Co., 3072 M St., NW, Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>JUN 1 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

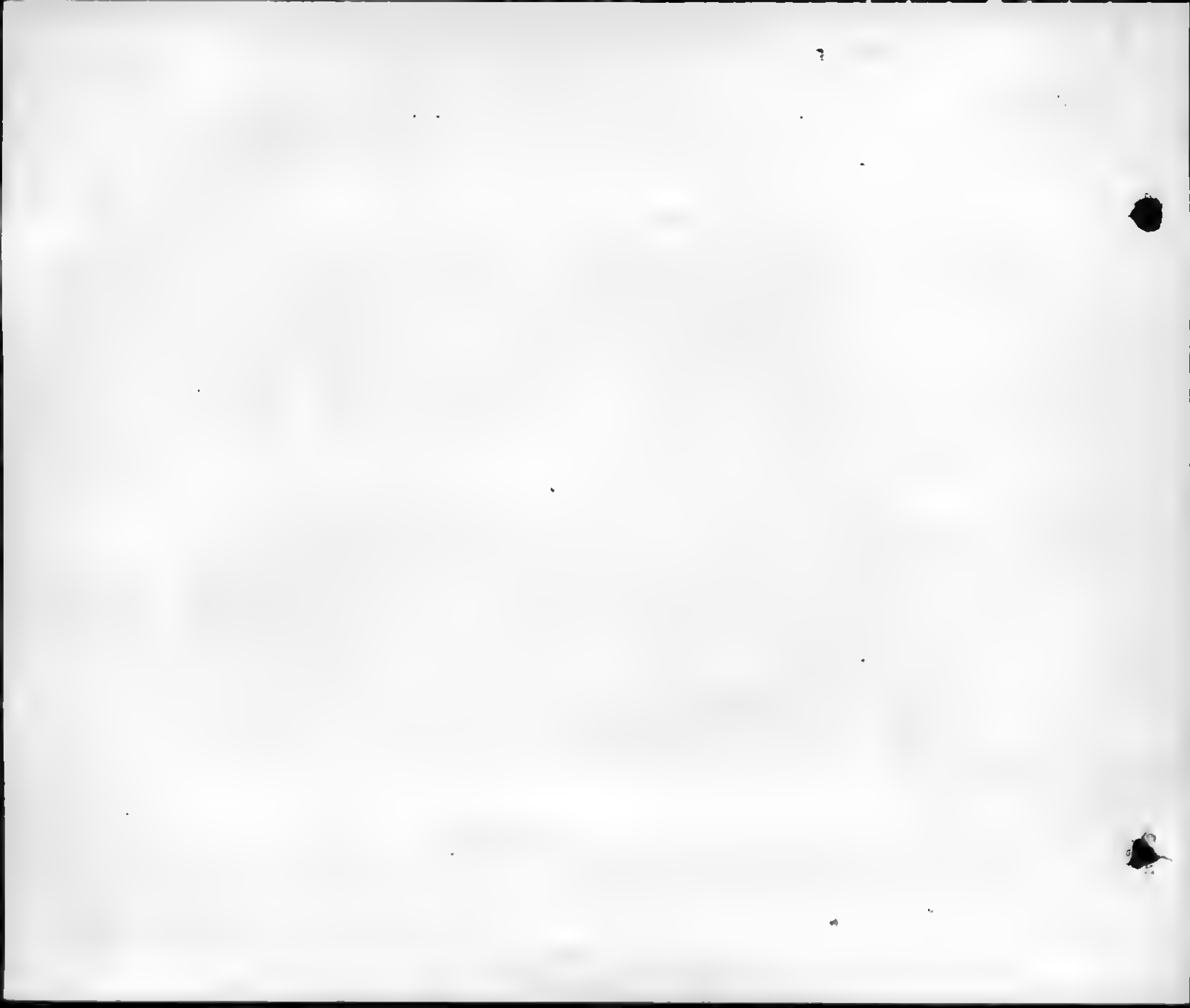
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05753

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>13 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4120 Military Road, N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>G</u> Last <u>Corey</u>				4. DATE OF DEATH Month <u>May</u> Day <u>1</u> Year <u>1961</u>			
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/71</u>		9. AGE (In years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11 BIRTHPLACE (State or foreign country) <u>N. Y.</u>	
12 CITIZEN OF WHAT COUNTRY? <u>Yes</u>				13. FATHER'S NAME <u>John murray</u>			
14. MOTHER'S MAIDEN NAME <u>Helicia murray</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>  </u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Irving M. Tuller</u>			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemiplegia with aphasia, severe</u> DUE TO (b) <u>Arteriosclerosis, generalised, advanced</u> DUE TO (c) <u>Essential hypertension, mod severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>10 yrs +</u> <u>10 yrs +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21 I certify that (I) (this hospital) attended the deceased from <u>1946</u> to <u>May 1</u> , 1961, that (I) (we) last saw the deceased alive on <u>Apr 26</u> , 1961, and that death occurred at <u>5:00 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp</u>				22b. DATE SIGNED <u>May 1 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>				22d. ADDRESS <u>4546 Chevy Chase Dr. Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Sp. city) <u>Buried</u>		23b. DATE THEREOF <u>5/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fair Lakes Em. / Bladensburg Rd. Md.</u>		23d. LOCATION (City, town, or county) (State) <u>  </u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Cheryl Chase</u>				25a. REC'D BY REGISTRAR <u>  </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5766

## CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>Stoney Creek Road</b>			
3. NAME OF DECEASED (Type or print) <b>ROBERT E. CORNWELL</b>				4. DATE OF DEATH <b>May 20, 1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>12/23/83</b>		9. AGE (In years last birthday) <b>77 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George W. Cornwell</b>				14. MOTHER'S MAIDEN NAME <b>Sara Ann Kidwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-8113</b>		INFORMANT <b>E. L. Cornwell</b> <b>306 W. Edmonston Drive Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>151X Carcinoma of stomach</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>5/16, 1961</b> to <b>5/20, 1961</b> that I last saw the deceased alive on <b>5/19, 1961</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above							DATE SIGNED <b>5/20/61</b>
ACTUAL SIGNATURE <b>Abraham W. Danish</b>				ADDRESS (Street, city or town, state) <b>927 Resolving Dr. Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>ABRAHAM W. DANISH</b>				902 <del>Highway</del> <b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/23/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE MAY 23 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Fikes</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5767  
CERTIFICATE OF DEATH

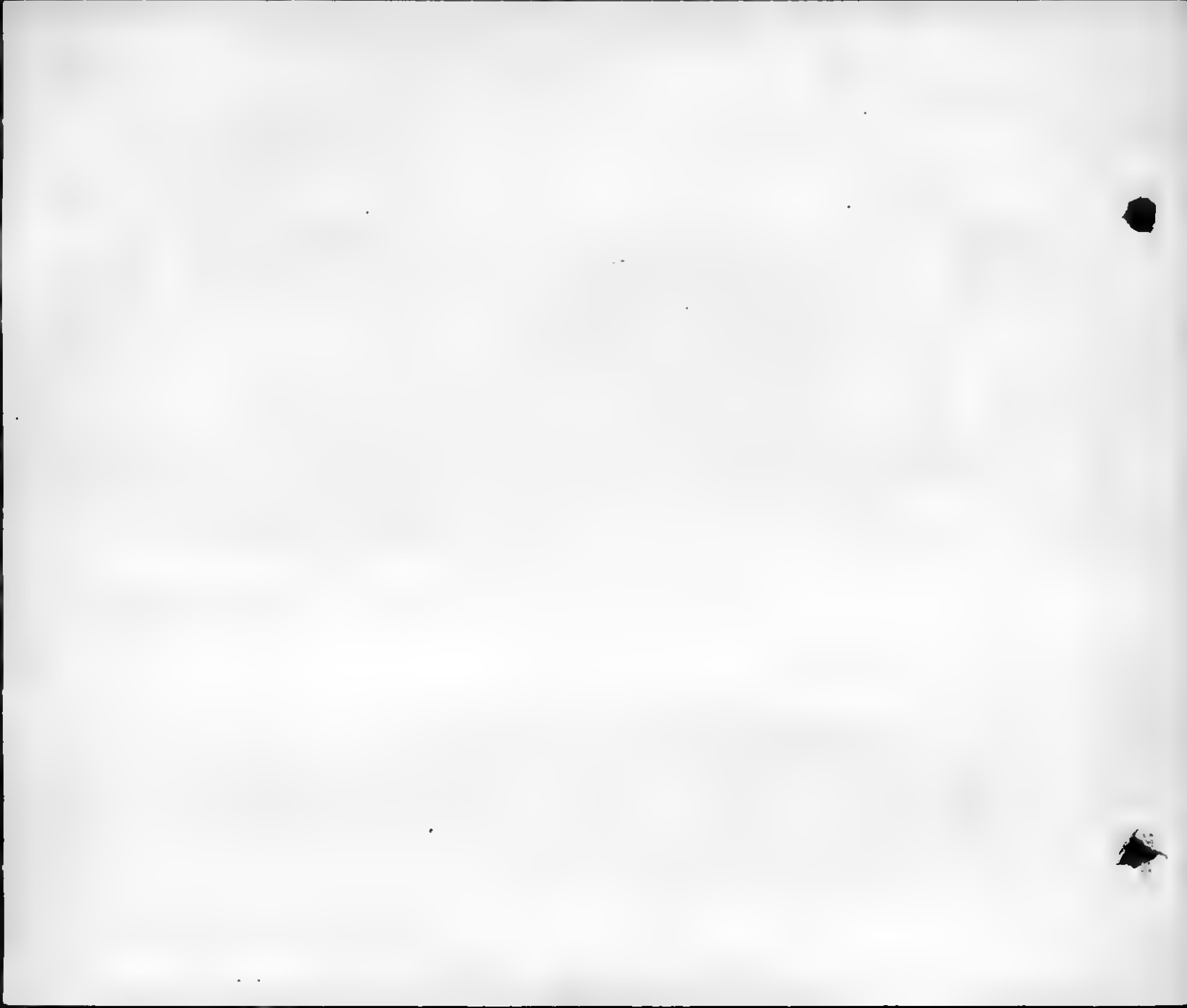
Reg. Dist. No.

05755

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11118 NORLEE DR</u>				d. STREET ADDRESS <u>11118 NORLEE DR.</u>			
3. NAME OF DECEASED (Type or print) <u>MINNIE</u> First <u>COZIER</u> Middle Last				4. DATE OF DEATH <u>May 5, 1961</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT-12-1884</u>	
				9. AGE (In years last birthday) <u>76</u> yrs		10. UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>DEBANOV</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>IRWIN COZIER - 11118 NORLEE DR</u> Address <u>5514 MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pancreas</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 19, 59</u> to <u>May 5, 1961</u> , that I last saw the deceased alive on <u>April 30, 1961</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Bernard Katzman</u> M.D. <u>3550 - Minn. Ave. S.E. S.W.</u>							
PHYSICIAN'S NAME (Type) <u>BERNARD KATZMAN M.D.</u> <u>Wash. 1912-C</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/7/61</u>		<u>SHARRE TORAH CEM</u>		<u>FITZBURGH, PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hines</u> ADDRESS <u>4217-9th</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

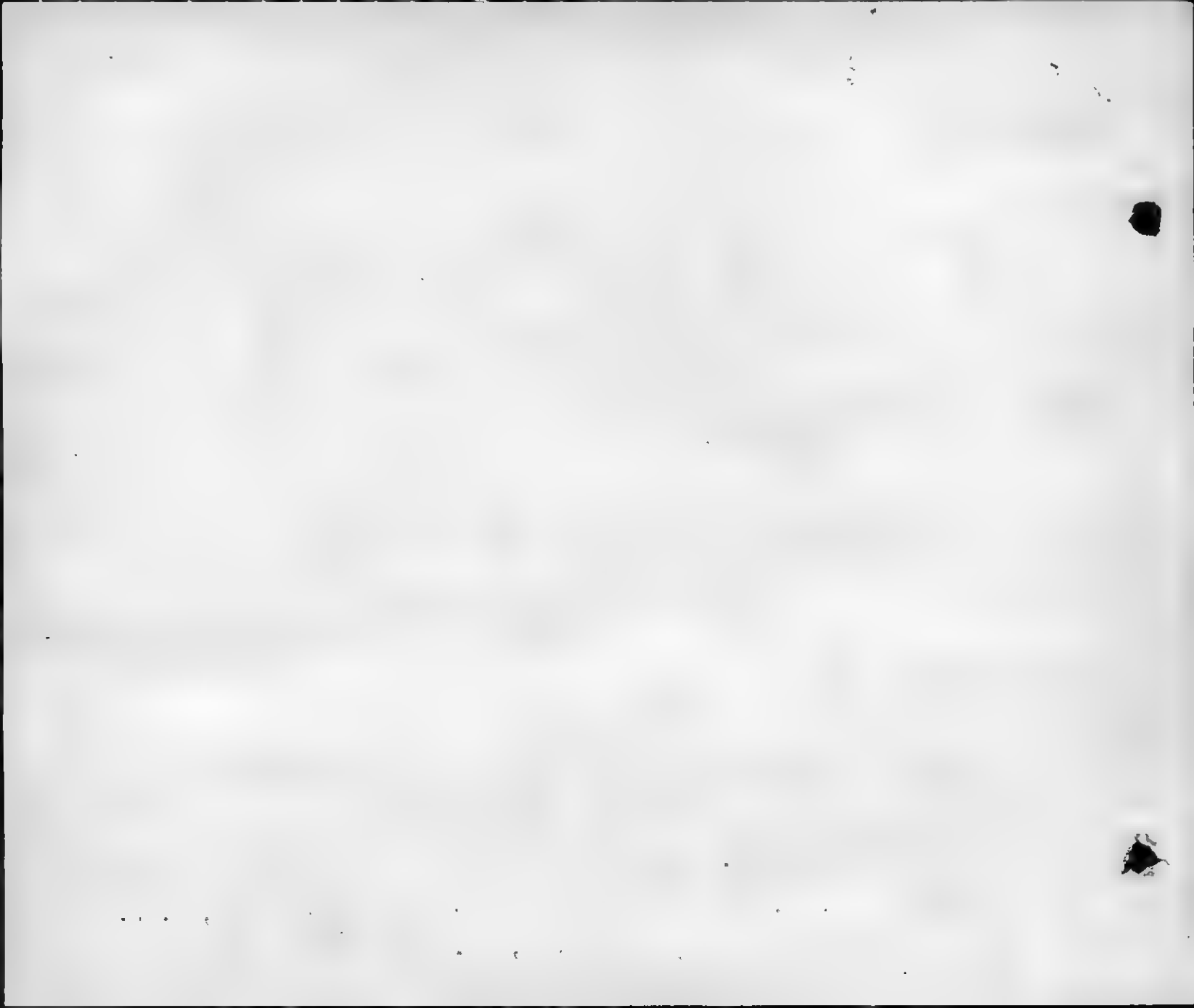
## CERTIFICATE OF DEATH

5768

05756

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Su. Curran</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>The President - 202</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Margaret Elliott Craig</u> First Middle Last <b>4. DATE OF DEATH</b> <u>May 12 1961</u> Month Day Year		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/18/80</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years, if UNDER 1 YEAR, last birthday) <u>80</u> yrs. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u> <b>11. BIRTHPLACE</b> (Country & State, or foreign country) <u>Washington, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>William Elliott</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Eckhardt</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <u>no</u> <b>16. SOCIAL SECURITY NO</b> <u>NONE</u> <b>17. INFORMANT</b> <u>Mrs. W. H. Rogers</u> Address <u>5910 - Wood Rd. Washington, D.C.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>5/9/61</u> Hour a.m. <u>19</u> p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/9/61</u> <b>1961</b> <b>to</b> <u>5/12/61</u> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>5/12/61</u> <b>1961</b> , <b>and that death occurred at</b> <u>11 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Michel M. Healy</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>MICHEL M. HEALY</u>		<b>22b. DATE SIGNED</b> <u>5/12/61</u> <b>22d. ADDRESS</b> <u>Washington, D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>5-16-61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u> <b>23d. LOCATION</b> (City, town or county) <u>Washington, D.C.</u> (State) <u>D.C.</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R.A. Humphrey</u> <b>ADDRESS</b> <u>Bethesda, Md.</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE MAY 18 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no case, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

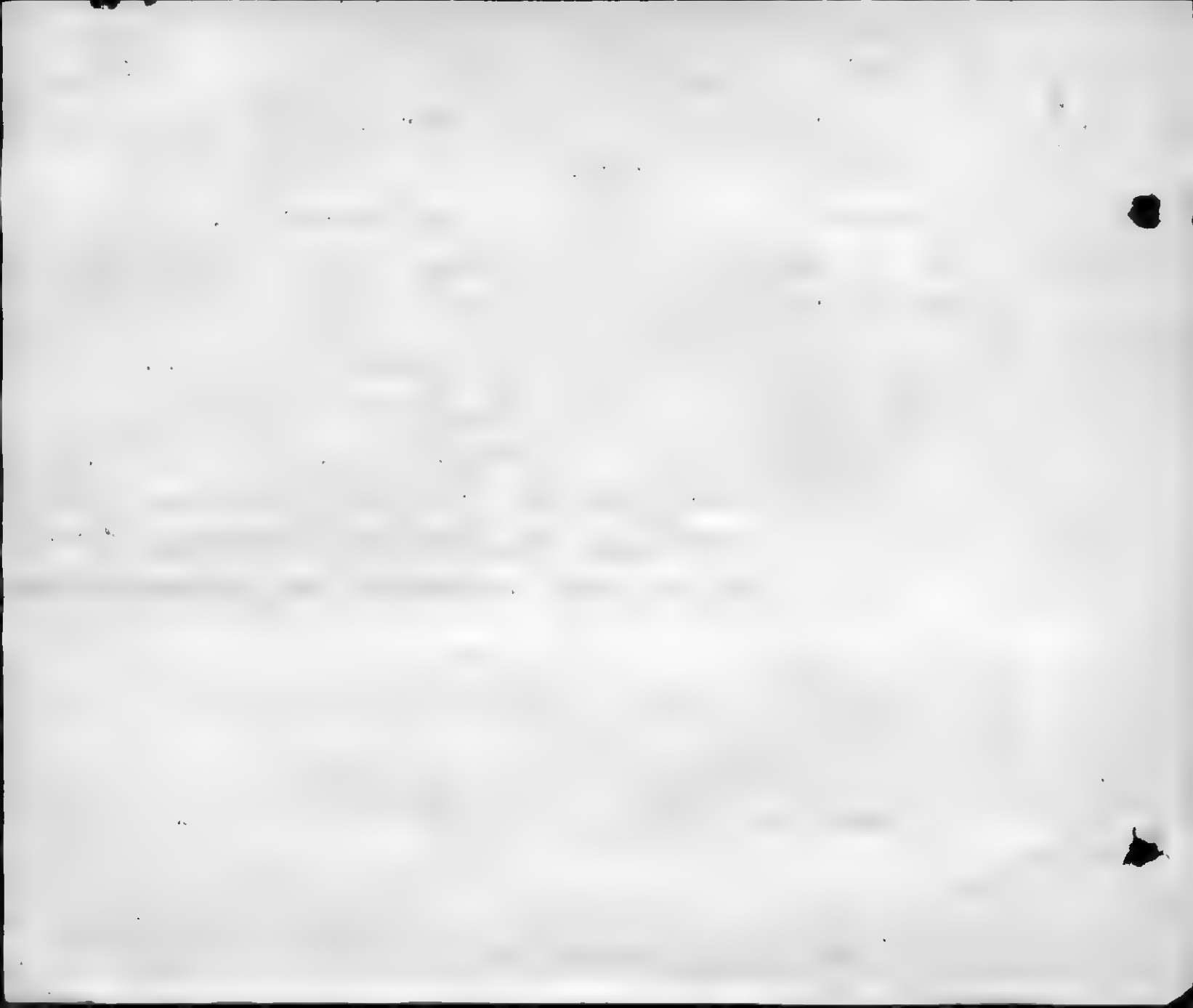
## CERTIFICATE OF DEATH

5769

05757

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in days <b>45 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		d. STREET ADDRESS <b>4027 Plyers Mill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph</b>		First		Middle		Last		4. DATE OF DEATH <b>5</b> <b>10</b> <b>1961</b>		Month		Day		Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/8/08</b>		9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York State</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Samuel Crockett</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn</b>		Address <b>327 S. Maplewood</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Bernice A. Crockett, Wife Chicago, Ill.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>confluent bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple Emboli, Brain, Kidney</b> DUE TO (c) <b>Myocardial Infarction = mural thrombi</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10d</b> <b>2 months</b> <b>2 months</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... 19... to... 19..., that (I) (we) last saw the deceased alive on... <b>9 May 1961</b> ... and that death occurred at... M, from the causes and on the date stated above.		22a. SIGNATURE <b>Merton L. White</b>		22b. DATE SIGNED <b>10 May 61</b>		22c. PHYSICIAN'S NAME (Type) <b>Merton L. White</b>		22d. ADDRESS <b>11134 Georgia Ave Silver Spring, Md.</b>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <b>11134 Georgia Ave Silver Spring, Md.</b>		22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>5/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Memorial</b>		23d. LOCATION (City, town or county) (State) <b>Sandy Spring, Md.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		24b. ADDRESS <b>Rockville, Md.</b>		25a. RECORDING REQUESTED <b>MAY 15 '61</b>		25b. REGISTRAR'S SIGNATURE <b>21-8 times</b>	





1  
FOR STATE  
HEALTH DEPT.

This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or is designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5770

05758

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Mont.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsda</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsda</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Suburban</i>			d. STREET ADDRESS <i>10531-Catlyn Drive</i>		
3. NAME OF DECEASED (Type or print) <i>Matthew</i>			4. DATE OF DEATH Month <i>May</i> Day <i>24</i> Year <i>1961</i>		
5. SEX <i>male</i>			6. DATE OF BIRTH <i>Oct. 15 1890</i>		
6. COLOR OR RACE <i>colored</i>			7. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>70</i> yrs. Months Days Hours Min.		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BIRTHPLACE (State or foreign country) <i>Maryland</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer (ret.)</i>			10b. KIND OF BUSINESS OR INDUSTRY		
11. FATHER'S NAME <i>William Curtis</i>			12. MOTHER'S MARRIAGE NAME <i>Unknown</i>		
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <i>yes unknown</i>			14. SOCIAL SECURITY NO. 17. INFORMANT <i>Lillian Williams</i> Address <i>Sage 85 Above.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>4201</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. <i>History of previous coronary disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
SIGNATURE <i>Frank J. Broschert</i> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>FRANK J. Broschert</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>5/31/61</i>		
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>			22d. LOCATION (City, town, or country) (State) <i>Arlington, Va.</i>		
23. FUNERAL DIRECTOR <i>Robert L. Frank</i> ADDRESS <i>Rockville, Md.</i>			24a. REC'D BY REGISTRAR <i>May 29 '61</i> DATE		
			24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5771  
CERTIFICATE OF DEATH  
05759

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>5300 Sherrill Avenue</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5300 Sherrill Avenue</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>5300 Sherrill Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE ANN CUSICK</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1961</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 22, 1881</b>	
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>12</b>		11. IF UNDER 24 HRS. Hours <b>12</b> Min. <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. PLACE County & State, or foreign country <b>Washington, D. C. USA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas D. Ross</b>		14. MOTHER'S MAIDEN NAME <b>Ida Wood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>June C. Dowdall-daughter-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Primary Cancer of Stomach</b> (c) DUE TO causes listed, stating the underlying cause last. <b>Arteriosclerotic Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 12, 1960</b> to <b>May 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 3, 1961</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>John R. Ewan</b>		22b. DATE SIGNED <b>5-4-61</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN R. EWAN - M.D.</b>	
22d. ADDRESS <b>1835 Eye St. N.W. Wash. D.C.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>	
24. ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

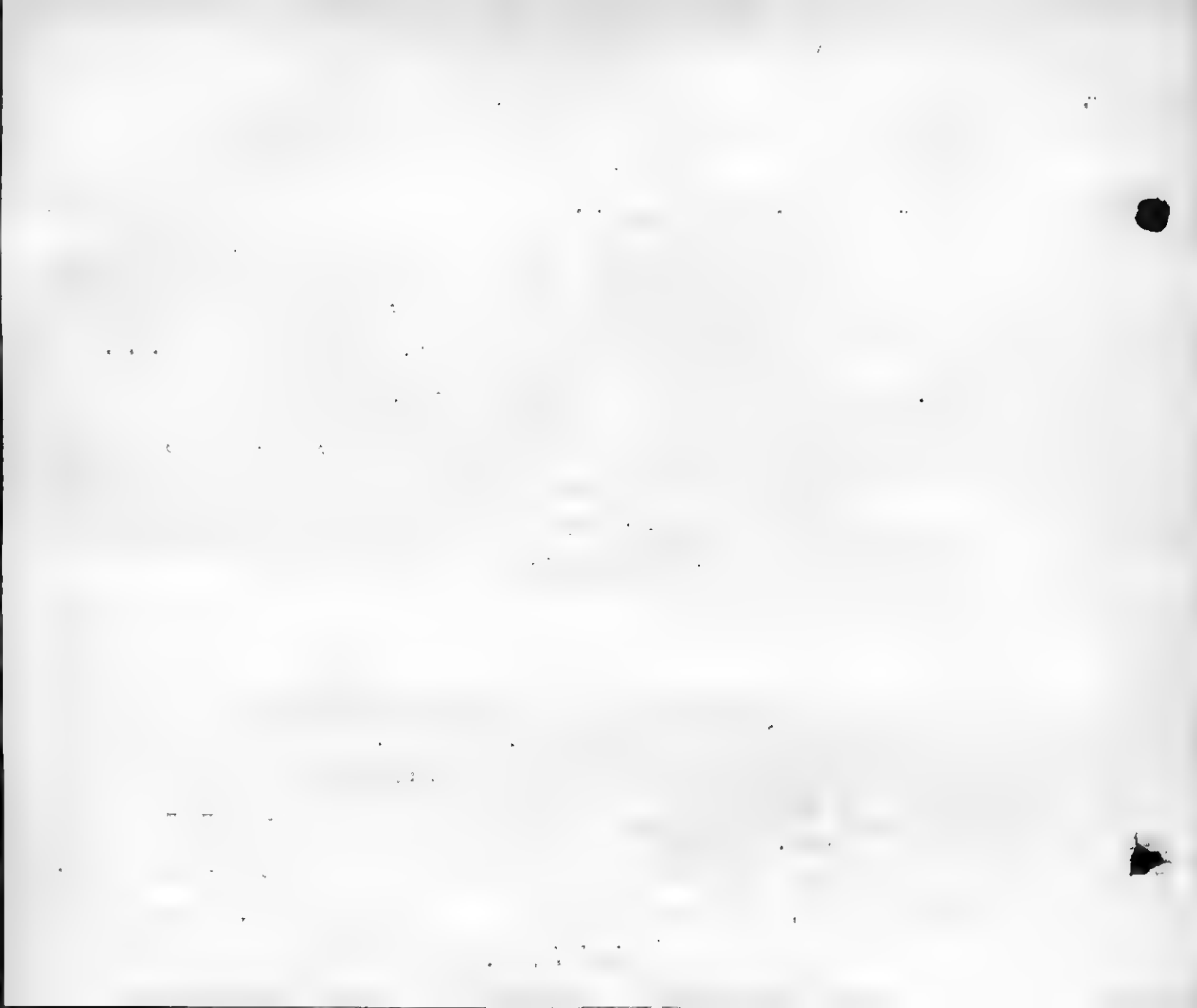
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15M 9/59

5772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05760

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Beulah</b> Middle <b>May</b> Last <b>Davies</b>		4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1900</b>
9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months <b>60</b> Days <b>11</b> Hours <b>19</b> Min <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Holsinger</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Mason</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 14 DUE TO <b>Hypertensive CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Myasthenia Gravis</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>April 17, 1961</b> to <b>May 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 11, 1961</b> , and that death occurred <b>May 11, 1961</b> from the causes and on the date stated above 22a. SIGNATURE <b>David A. Drachman</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>5-12-61</b> 22b. DATE SIGNED <b>5-12-61</b> 22c. PHYSICIAN'S NAME (Type) <b>David A. Drachman</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 15, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Comfort</b>		23d. LOCATION (City, town, or county) (State) <b>Fairfax Co. Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. Bessly Mount Comfort</b>		25a. REC'D BY REGISTRAR <b>P. O. Box 65 Alexandria, Va.</b>	
25b. REGISTRAR'S SIGNATURE <b>G. L. K. K.</b>		DATE <b>MAY 15 '61</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased was not in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased was not in the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5773

05761

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) <b>STATE</b> <b>District of Columbia</b>	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		<b>c. LENGTH OF STAY IN TB</b> <b>36 days</b>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>d. STREET ADDRESS</b> <b>3313 16th Street, N. W.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Thomas Louis DEGNAN</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>May 16 19 61</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>6-5-94</b>	
<b>9. AGE</b> (In years) IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday Months Days Hours Min. <b>66 yrs.</b>		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Admin. Clerk</b>		<b>12. BUSINESS OR INDUSTRY</b> <b>Maritime Comm.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Degnan</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary O'Brien</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>1918 to 1919 579-24-1707(B)</b>	
<b>17. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Carcinoma tongue with metastasis</b> <b>1111 9</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>DUE TO</b> <b>(b)</b> <b>(c)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 1/2 yrs.</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> <b>(this hospital)</b> attended the deceased from <b>April 10</b> 19 <b>61</b> to <b>May 16</b> 19 <b>61</b> , that <b>we</b> last saw the deceased alive on <b>May 16</b> 19 <b>61</b> , and that death occurred at <b>7:40AM</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>T. E. Taylor</b>		<b>22b. DATE SIGNED</b> <b>5-16-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>T. E. TAYLOR, LT, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5-19-61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Arlington Virginia</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>DeVol Funeral Home, 2224 Wisconsin Ave., NW,</b>		<b>25a. REC'D BY REGISTRAR</b> <b>MAY 18 61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. ...</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

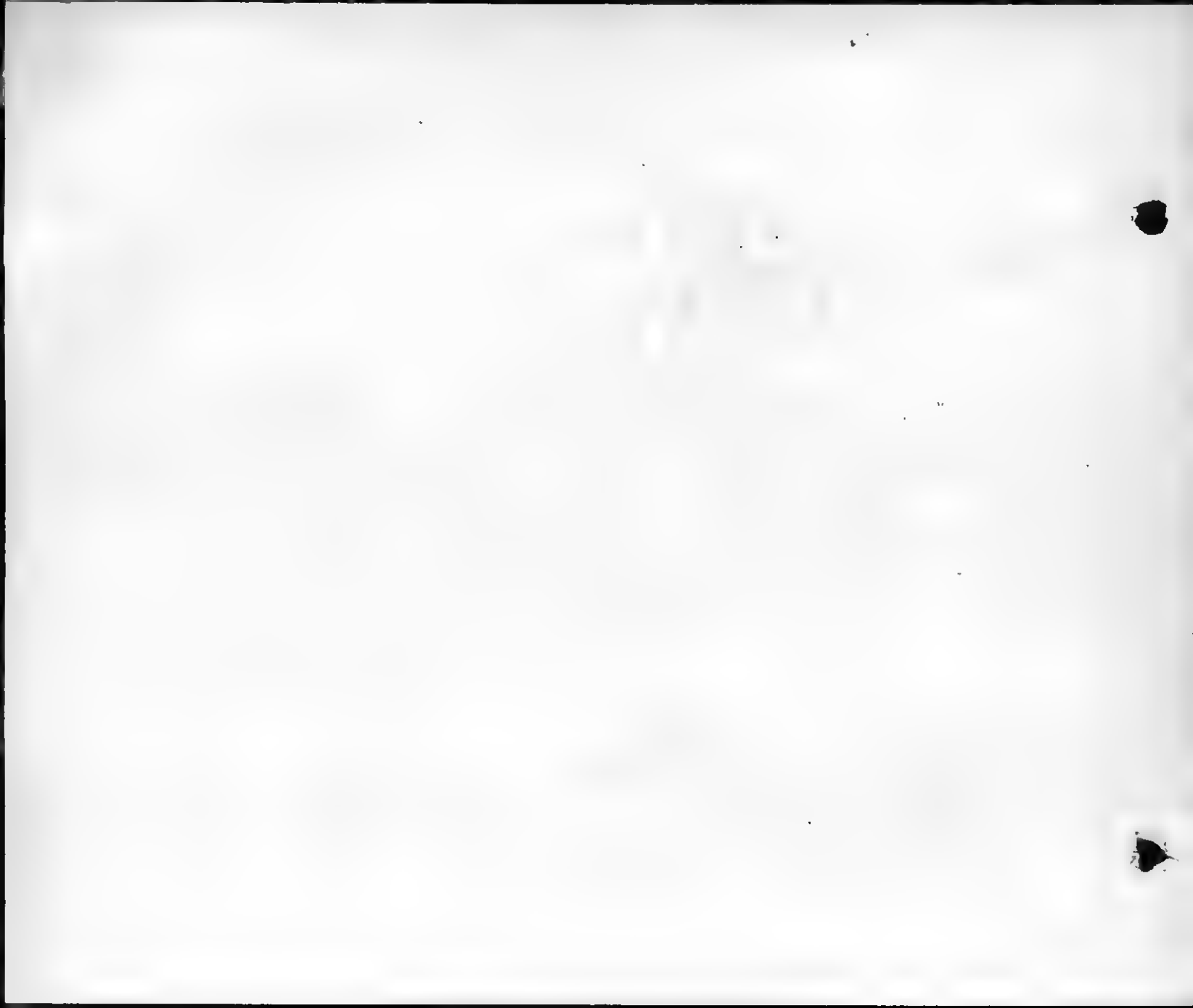
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5774

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No. 05762

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u> c. LENGTH OF STAY IN 1b <u>16 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 Vassar Circle</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u> d. STREET ADDRESS <u>11 Vassar Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alfred James</u> Middle <u>DePaolis</u> Last <u>DePaolis</u> 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>Apr 25 1899</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <u>62</u> yrs IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS		<b>4. DATE DEATH</b> Month <u>MAY</u> Day <u>18</u> Year <u>1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER SHOP</u> 11. BIRTHPLACE (State or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Giavani DePaolis</u> 14. MOTHER'S MAIDEN NAME <u>Louisa Bonbino</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>578610028</u> INFORMANT <u>Louis DePaolis</u> Address <u>11 Vassar Glen Echo Md</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO (b) <u>Carcinoma pancreas</u> DUE TO (c) <u>lyng cause lost</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>9 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 31, 1960</u> to <u>May 18, 1961</u> , that I last saw the deceased alive on <u>May 17, 1961</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. F. Quayle</u> M.D. ADDRESS (Street, city or town, state) <u>1820 Belmont St. Wash. D.C.</u>		DATE SIGNED <u>May 23 1961</u>	
PHYSICIAN'S NAME (Type) <u>E. F. Quayle M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 22, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. De Vol</u> ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>May 23 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **06908**

WT. **161 lb** 5775 12 months

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>Platong.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				c. LENGTH OF STAY IN 1b <b>16</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>DEERY</b> Last <b>DEERY</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/1911</b>	
9. AGE (In years last birthday) yrs. <b>50</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min. <b>2</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOHN ALVIN DEERY</b>				14. MOTHER'S MAIDEN NAME <b>MILDRED VIRGINIA KRI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MOTHER</b>		Address <b>SAME AS ABOVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PREMATURITY</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>—</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/23</b> , 19 <b>61</b> , to <b>5/25</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/25</b> , 19 <b>61</b> , and that death occurred at <b>3:54</b> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>—</b> DATE SIGNED <b>—</b>							
ACTUAL SIGNATURE <b>Dr. W. Pearlman</b> M.D.				PHYSICIAN'S NAME (Type) <b>—</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>5/27/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SUBURBAN HOSPITAL</b>		22d. LOCATION (City, town, or county) (State) <b>BETHESDA, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Amelia Carter</b>				24a. REC'D BY REGISTRAR <b>DATE JUN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5776

05763

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institutions; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u> d. STREET ADDRESS <u>4501 Brandon Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Agnes Irene Dodd</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>MAY 18 1961</u>		<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>FEB. 9, 1881</u>		<b>9. AGE</b> (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.: Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS - HSWF. PRIVATE</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>No. Thumberland Co., Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN? - BRYANT</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>				<b>17. INFORMANT</b> Address <u>William H. Richards (son) as above</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Irreversible shock</u> (b) <u>Pulmonary embolism</u> (c) <u>Peripheral venous thrombosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u> <u>unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER!)														<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>5/16, 1961</u> to <u>5/18, 1961</u> , that (I) (we) last saw the deceased alive on <u>5/18, 1961</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above.																			
<b>22a. SIGNATURE</b> <u>Abraham W. Danish</u>						<b>22b. DATE SIGNED</b> <u>5/19/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ABRAHAM W. DANISH</u>		<b>22d. ADDRESS</b> <u>927 Pershing Dr. Silver Spring, Md</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>May 22, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Comm. Inc</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Hyattsville, D.C.</u>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. N. Charnick</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DATE 5 MAY 22 1961</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## 05764

5777

VR A15 (4)  
15M 9/11

M



1. PLACE OF DEATH  
a. COUNTY Montgomery

2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)  
a. STATE md. b. COUNTY Montgomery

3. NAME OF DECEASED (Type or print) Mr. Stella Viretta Dodd

4. STREET ADDRESS 18119 Hammond Ave.

5. SEX Fe 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 6/6/44

9. AGE (In years last birthday) 86 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF

11. BIRTHPLACE (County & State or foreign country) OHIO 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Patton 14. MOTHER'S MAIDEN NAME Elizabeth Coler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Chart Record at Hospital

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
(a) IMMEDIATE CAUSE (a). 491X DUE TO Bronchopneumonia  
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 5/1 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/8 1961, to 5/1 1961, that (I) (we) last saw the deceased alive on 5/1 1961, and that death occurred at 10:25 AM from the causes and on the date stated above.

22a. SIGNATURE Eino Magi M.D. 22c. PHYSICIAN'S NAME (Type) EINO MAGI 22d. ADDRESS 918 Univ. Blvd. E., Silver Spring, Md.

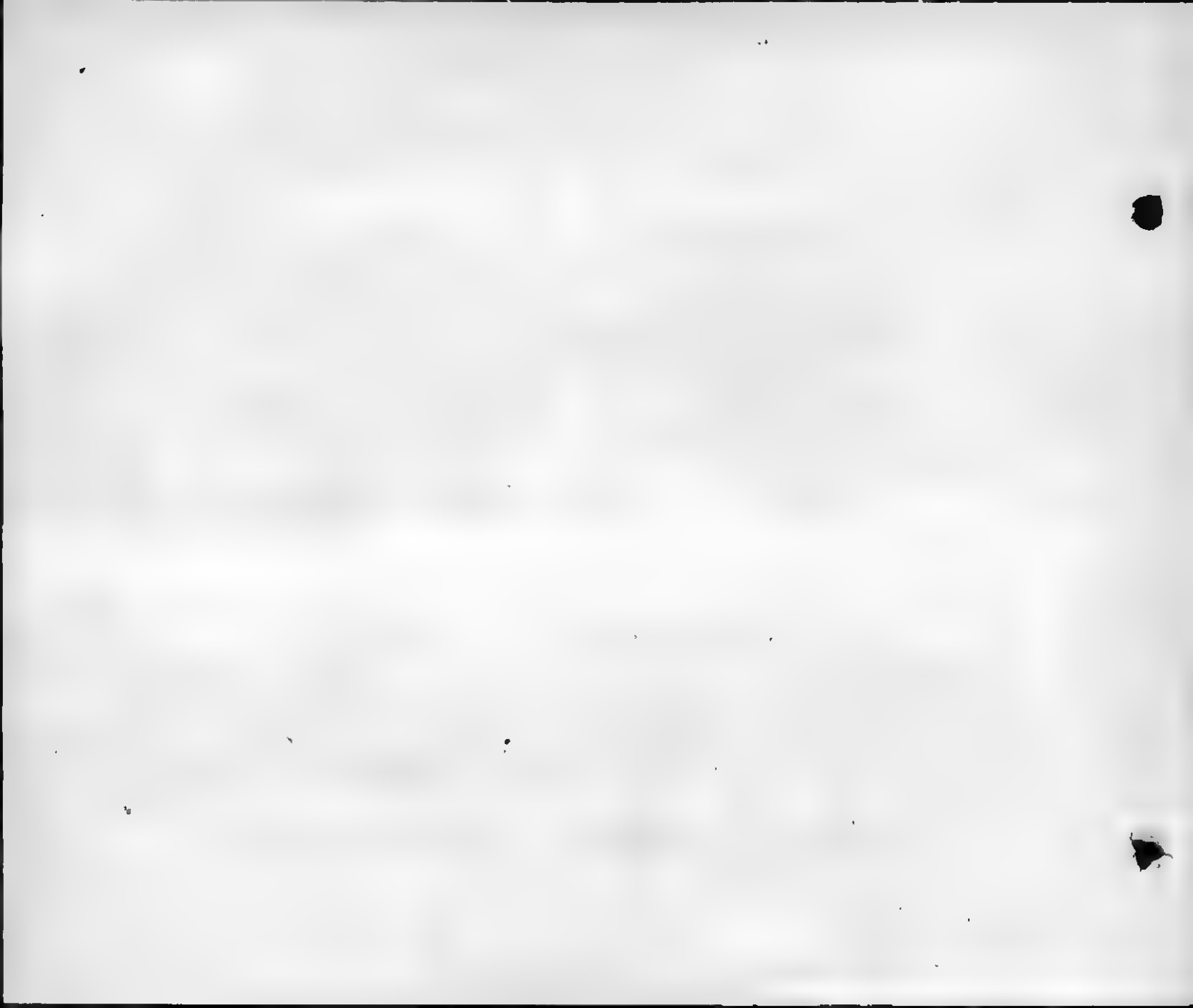
22b. DATE SIGNED 5/1/61

23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial 23b. DATE THEREOF 5/3/61 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill 23d. LOCATION (City, town or county) (State) Southland Md.

24. FUNERAL DIRECTOR'S SIGNATURE Frank Teiers Sons Co ADDRESS 3605-14 Edgemoor 25a. REC'D BY REGISTRAR DATE MAY 3 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines

Wash. D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
3778  
05765  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IL <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Senior Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u> d. STREET ADDRESS <u>7804 Lockney Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Louis Michael Dorsch</u>		4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1961</u>		5. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6. SEX <u>Male</u>		7. COLOR OR RACE <u>White</u>		8. DATE OF BIRTH <u>8-8-77</u>			
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years last birthday) <u>81</u> yrs.		11. IF UNDER 1 YEAR Months Days Hours Min.			
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker (Retired)</u>		13. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>		14. BIRTHPLACE, County & State, or foreign country <u>U.S.A.</u>			
15. FATHER'S NAME <u>Michael Dorsch</u>		16. MOTHER'S MAIDEN NAME <u>Catherine (Unknown)</u>		17. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>		19. SOCIAL SECURITY NO. <u>578-09-6745</u>		20. INFORMANT <u>Hospital Records</u>			
21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Insufficiency</u> (c) <u>Old Coronary Aneurysm due to Arteriosclerosis</u> DUE TO cause last. (d) <u>Supra Pubic Prostatectomy 5-3-61</u>							
22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 3 hrs.</u>							
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>							
24. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>							
25. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
28. (City or town) <u>Prince George County</u>		29. (County) <u>Md.</u>		30. (State) <u>MD</u>			
31. I certify that (I) <u>Paul E. Fanet</u> attended the deceased from <u>April 10, 1961</u> to <u>May 4, 1961</u> , that (I) <u>Paul E. Fanet</u> saw the deceased alive on <u>May 4, 1961</u> , and that death occurred at <u>7804 Lockney Ave.</u> from the causes and on the date stated above.							
32. SIGNATURE <u>Paul E. Fanet</u>		33. DATE SIGNED <u>5-4-61</u>		34. DATE SIGNED <u>5-4-61</u>			
35. PHYSICIAN'S NAME (Type or print) <u>PAUL FANET</u>		36. ADDRESS <u>6727-16th St. N.W., Wash DC</u>		37. ADDRESS <u>6727-16th St. N.W., Wash DC</u>			
38. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		39. DATE THEREOF <u>May 8, 1961</u>		40. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
41. LOCATION (City, town or county) <u>Prince George County</u>		42. (State) <u>Md.</u>		43. (State) <u>MD</u>			
44. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		45. ADDRESS <u>Silver Spring Md.</u>		46. REC'D BY REGISTRAR <u>DATE MAY 9 '61</u>			
47. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>		48. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>		49. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			



1  
FOR STATE  
HEALTH DEPT.

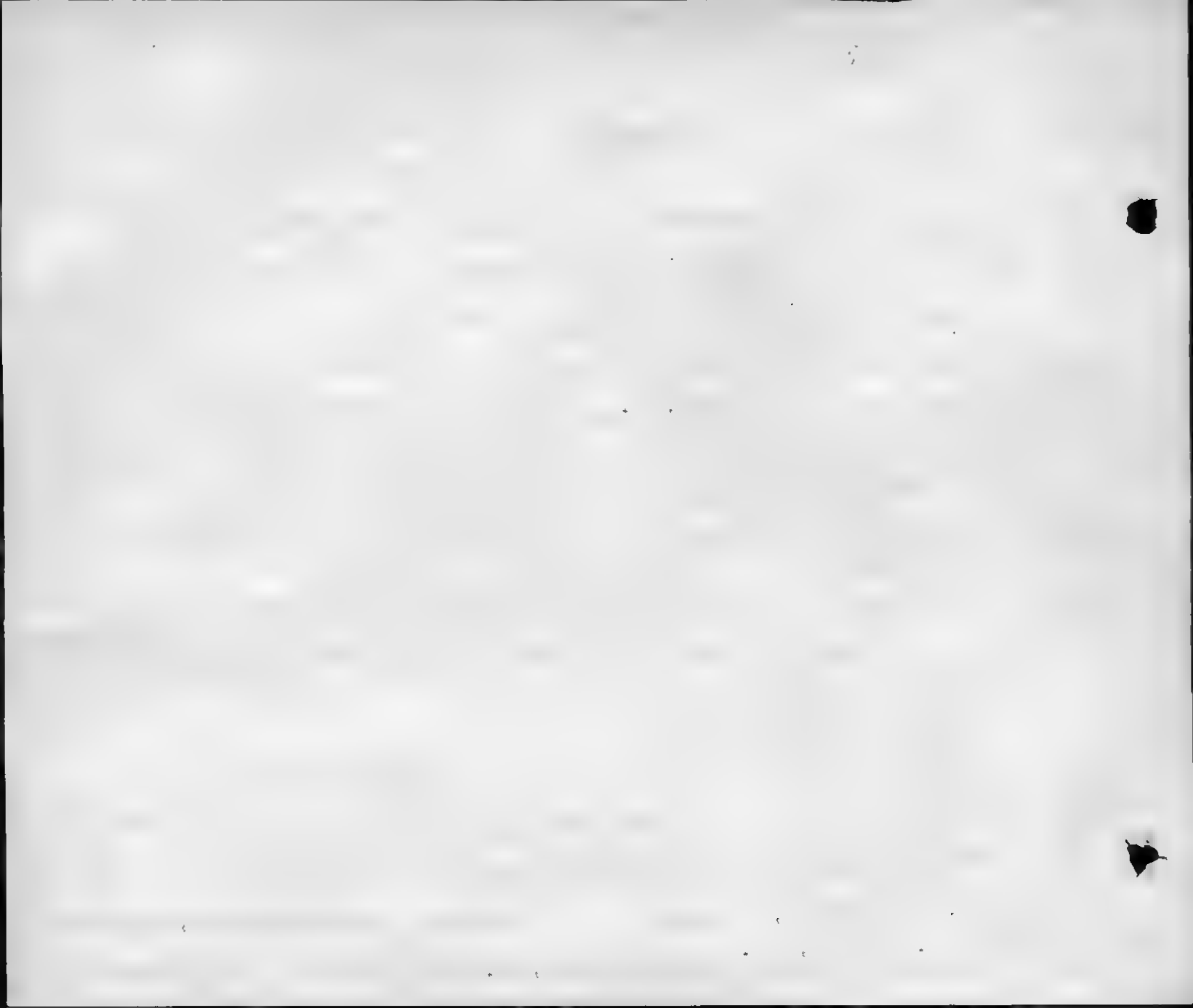
5778  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05766

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY in 1b <u>6 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1910 Rockland Ave</u>				d. STREET ADDRESS <u>1910 Rockland Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Alyse Margaret Dougherty</u>				4. DATE OF DEATH <u>May 22 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-30-1897</u> <u>63</u> yrs.	
9. AGE (In years last birthday) <u>63</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown Clark</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Gas. Jos Dougherty (husband) Steu</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <u>Acute cardiac failure</u> 153.8 DUE TO (b) <u>Carcinoma of lower bowel with metastasis</u> 6 yrs. (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschatz</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschatz</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>5-22-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
Burial-Transit May 26, 1961 West Laurel Hills Cemetery Montgomery County Philadelphia							
23. FUNERAL DIRECTOR ADDRESS <u>Warner E. Pumphrey, Inc. 8434 Georgia Avenue</u> <u>Silver Spring, Md.</u>							
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>							

VS. A15ME  
5M 9/60

DO NOT WRITE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



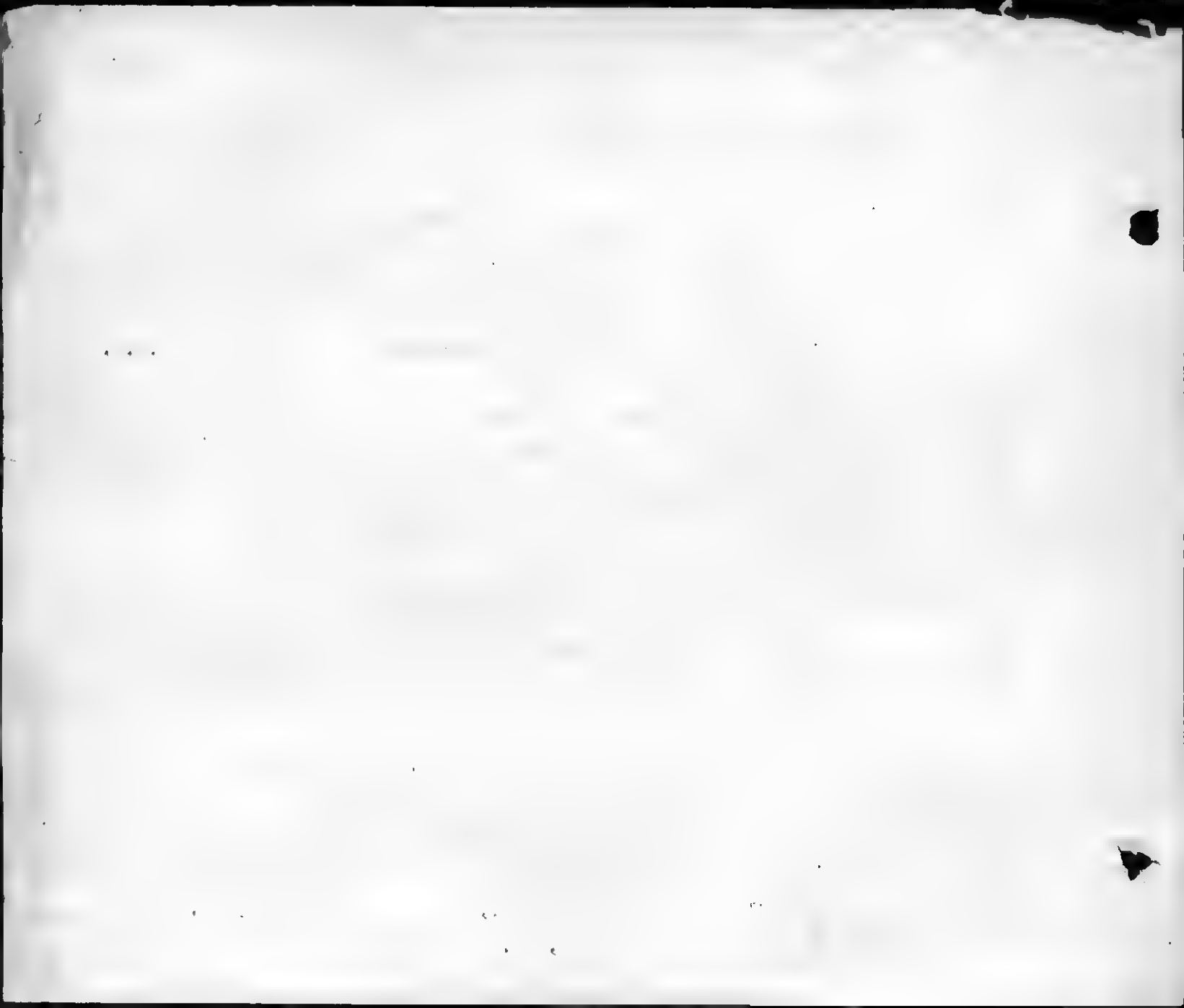
may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5780

05761

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL, and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>6806 - 7 Locks Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address; OR INSTITUTION) <u>6806 7 Locks Rd</u>		d. STREET ADDRESS <u>1 Cabin John</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Ellen</u> Last <u>Dove</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1894</u>
9. AGE (years, months, days) <u>66</u> yrs		10. UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>3</u> Hours <u>13</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lloyd T Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Forego Snowden Dove</u>	
17. INFORMANT <u>Forego Snowden Dove</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Circumferential Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1961</u> to <u>May 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1961</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William H Killay</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William H Killay</u>		22d. ADDRESS <u>8218 Wisconsin Ave Bethesda, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/17/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cabin John, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>May 19 1961</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

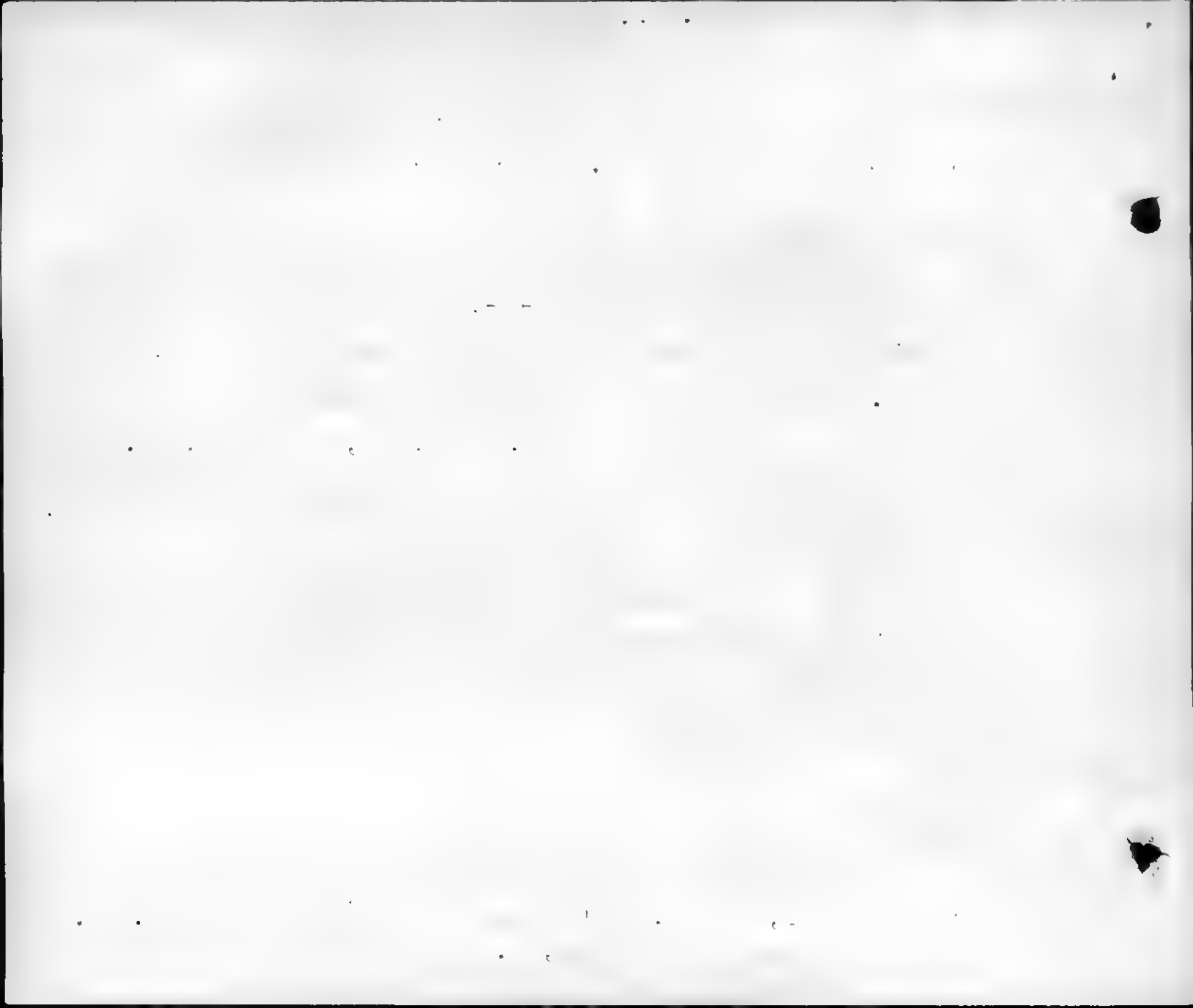
5781

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05768

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Germantown</b>		c. LENGTH OF STAY IN 1b <b>20 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Germantown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>ELLEN</b> Last <b>DOVE</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-28-1884</b>	9. AGE (in years last birthday) <b>76 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Sanford R. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Virginia (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Woodrow Dove, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEPATO-RENAL FAILURE</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>METASTATIC CARCINOMA</b> DUE TO (c) <b>CARCINOMA OF THE STOMACH</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b> <b>6 MONTHS</b> <b>1 YEAR</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LEFT HEMIPLEGIA</b> <b>HYPERTENSION</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1949</b> to <b>May 13, 1961</b> , that (I) (we) last saw the deceased alive on <b>12 MAY 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John Fawcett</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John Fawcett</b>				22d. ADDRESS <b>Laytonville P.O. Box, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 16, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Lutheran</b>		23d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5782

05769

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN town MARYLAND  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if not institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 6608 Rannock Road

3. NAME OF DECEASED (Type or print) WALLACE J DUGAS

4. DATE OF DEATH MAY 22 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 1/29/10

9. AGE (in years last birthday) 51 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Br. Mgr. Frick Co.

11. PLACE OF BIRTH Louisiana 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Ernest Dugas 14. MOTHER'S MAIDEN NAME Celina Daigel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Isabella Dugas Wife (Same as above)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Acute Myocardial Infarct. Ant.  
DUE TO (b) Moderate Arteriosclerosis  
DUE TO (c) Moderate Hypertension

INTERVAL BETWEEN ONSET AND DEATH 3 1/2 days  
5 years  
2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Chronic Fibrotic Emphysema & Asthma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) None

20c. TIME OF INJURY Month, Day, Year May 18, 1961 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Waynsboro (County) Waynsboro (State) Pennsylvania

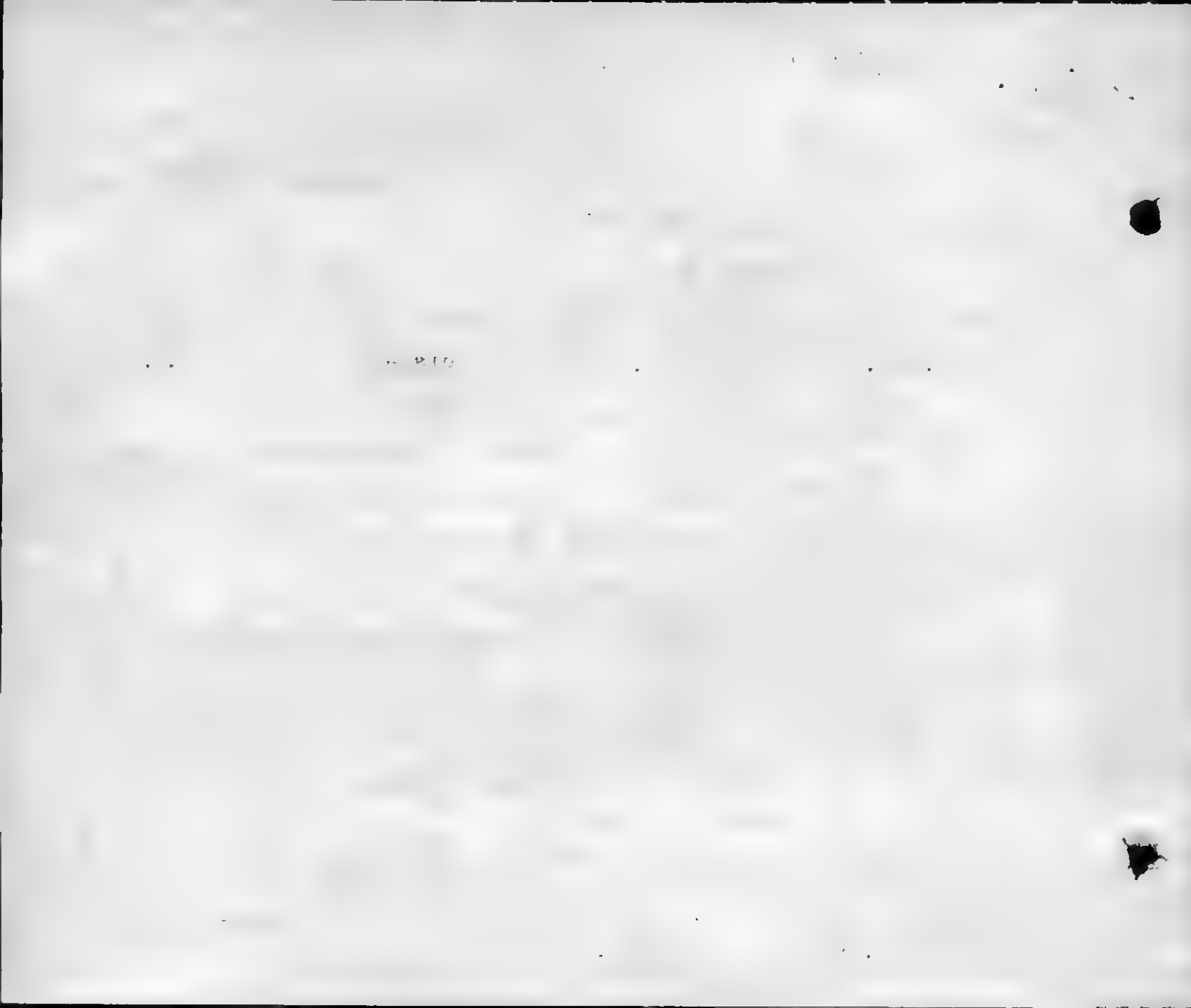
21. I certify that (I) (this hospital) attended the deceased from May 18, 1961 to May 22, 1961, that (I) (we) last saw the deceased alive on May 21, 1961, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE Gilbert B. Rude M.D. 22b. DATE SIGNED 5-22-61

22c. PHYSICIAN'S NAME (Type) Gilbert B. Rude 22d. ADDRESS 3900 Military Rd NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/25/61 23c. NAME OF CEMETERY OR CREMATORY Burns Hill Cemetery 23d. LOCATION (City, town or county) Waynsboro, Pennsylvania (State) Pennsylvania

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR May 25 '61 25b. REGISTRAR'S SIGNATURE Robert S. Kram



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5785

65710

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>12 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3117-45th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>GEORGE HARRISON DURAND</u>		<b>DEATH</b> DATE <u>May 19</u> 19 <u>61</u> Month Day Year	
<b>5. SEX</b> <u>male</u> <u>white</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		<b>19. AGE</b> (In years, if UNDER 1 YEAR, IF UNDER 24 HRS., last birthday) <u>92</u> yrs. Months Days Hours Min. 10b. <input type="checkbox"/> MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED 11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Cyrus LeTurner</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>no</u> <b>17. INFORMANT</b> <u>Harrison T. Durand</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Fibrillation</u> (b) <u>coming into contact with hot water</u> (c) <u>stroke</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(s) <u>no</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 19, 1961</u> <b>to</b> <u>May 19, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>May 19, 1961</u> , <b>and that death occurred at</b> <u>5:30 PM</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Arthur L. Hines</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Arthur L. Hines</u> <b>22d. ADDRESS</b> <u>Washington Clinic, Washington, D.C.</u> <b>22e. DATE SIGNED</b> <u>5/19/61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u> <b>23b. DATE THEREOF</b> <u>5/22/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Yankton Cemetery</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>South Dakota</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>S.H. Hines Co.</u> <b>25a. REC'D BY REGISTRAR</b> <u>DATE MAY 22 '61</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>	

1 NO. 10.

2

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05771**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>Garrett Park</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>11013 Montrose Ave.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b> d. STREET ADDRESS <b>11013 Montrose Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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<b>3. NAME OF DECEASED</b> (Type or print) First <b>LEON</b> Middle <b>Lamar</b> Last <b>DYE</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>20</b> Year <b>19 61</b>		<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>Nov. 21, 1871</b> <b>9. AGE</b> (In years and birthday) <b>89</b> yrs. <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Major USMC</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Miss.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
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<b>13. FATHER'S NAME</b> <b>Thomas Jefferson Dye</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Leticia Longmire</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1 and 2</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Williston L. Dye-son-9709 Bellevue Drive</b> Address <b>Bethesda, Md.</b>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Cornary occlusion</b> <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> <b>DUE TO</b> <b>(c)</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>	
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<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour <b>a. m.</b> <b>p. m.</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	

<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		<b>ACTUAL SIGNATURE</b> <b>Frank J. Broschart</b> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <b>Frank J. Broschart</b> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>5/24/61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington Nat. Cem.</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Arlington, Virginia</b>	

<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey</b> <b>ADDRESS</b> <b>Bethesda, Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>MAY 23 '61</b> <b>24b. REGISTRAR'S SIGNATURE</b> <b>C. W. S. Kline</b>	
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one signature is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5785

05772

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>25 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ADOLPHUS</b> Middle <b>(NMN)</b> Last <b>EDWARDS</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>6</b> Year <b>19 61</b>			
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-92</b>	
9 AGE (In years lost birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours M n.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BD. OF EDUCATION</b>		11 BIRTHPLACE (State or foreign country) <b>NEBRASKA</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13 FATHER'S NAME <b>JAMES EDWARDS</b>				14. MOTHER'S MAIDEN NAME <b>MATTIE JOHNSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17 INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, MARYLAND</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary and Cerebral Emboli</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Mural Thrombus</b> <b>1) 3 wks</b>							
(c) <b>Myocardial Infarction</b> <b>2) 3 months</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from <b>APRIL 11</b> <b>19 61</b> , to <b>MAY 6</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 6</b> <b>19 61</b> , and that death occurred at <b>12:40 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert A. Yates</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>5/6/61</b>	
22c PHYSICIAN'S NAME (Type) <b>R.A. YATES, M.D.</b>				22d ADDRESS <b>OLNEY, MARYLAND</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5/10/61</b>		23c NAME OF CEMETERY OR CREMATORY <b>Arlington National.,</b>		23d LOCATION (City, town, or county) (State) <b>Arlington, Va..</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Suroden</b>				ADDRESS <b>Rockville, Md.</b>		25a. RECORD BY REGISTRAR DATE <b>MAY 10 1961</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			

(M)

(I)

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5786

## CERTIFICATE OF DEATH

052773

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>211 E. Hanover Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> First <u>Edward</u> Middle <u>Edwards</u> Last <u>Edwards</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>9</u> Year <u>1961</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-17-73</u>		<b>9. AGE</b> (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.							
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Minister</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Sweden</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>							
<b>13. FATHER'S NAME</b> <u>John Edwards</u>				<b>14. MOTHER'S MAIDEN NAME</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Hosp record</u> Address					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Pulmonary edema</u> Condition (b) <u>gave rise to immediate cause</u> DUE TO <u>Congestive heart failure</u> (c) <u>stating the underlying cause last.</u> DUE TO <u>Arteriosclerotic heart disease</u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Diabetes mellitus</u>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)												<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/29</u> <u>1961</u> , to <u>5/9</u> <u>1961</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>5/9</u> <u>1961</u> , and that death occurred at <u>6</u> <u>p.m.</u> , from the causes and on the date stated above.												<b>22a. SIGNATURE</b> <u>Eino Magi</u>		<b>22b. DATE SIGNED</b> <u>5/9/61</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>EINO MAGI</u>		<b>22d. ADDRESS</b> <u>918 Univ. Blvd E. Silver Spring, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>May 12, 1961</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>George Washington Cemetery</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Prince George County, Md.</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. Arthur Walters, 254 Carroll St NW DC</u>												<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAY 12 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. J. Jones</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

5787

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05774

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>10 min.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Roland Mason Fennington</b>		4. DATE OF DEATH Month Day Year <b>May 13 19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>W</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11/5/1888</b>
9 AGE (In years last birthday) <b>72</b> yrs		F UNDER 1 YEAR Months Days Hrs Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Heavy Construction</b>	
11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CIT ZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Fennington</b>		14. MOTHER'S MAIDEN NAME <b>Annie Nicholson Huff</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17 INFORMANT <b>Mrs. Russell Bryan</b>		Address <b>Brookeville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Blood loss shock (internal bleeding)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Probable rupture of abd. aortic aneurysm</b> (c) DUE TO <b>Arteriosclerotic Cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>_____</b>	
20c TIME OF INJURY Month, Day, Year Hour o m p m <b>_____ 19 _____</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>_____</b>		20f (City or town) (County) (State) <b>_____</b>	
21 I certify that (I) (this hospital) attended the deceased from <b>5/13/1961</b> to <b>5/13/1961</b> that (I) (we) last saw the deceased alive on <b>5/13/1961</b> and that death occurred at <b>5 PM</b> from the causes and on the date stated above			
22a SIGNATURE <b>John P. Martin</b>		22b DATE SIGNED <b>May 14 1961</b>	
22c PHYSICIAN'S NAME (Type) <b>JOHN P. MARTIN, MD</b>		22d ADDRESS <b>SANDY SPRING, MD</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 17, 1961</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Brookeville</b>		23d LOCATION (City, town, or county) (State) <b>Brookeville, Md.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		ADDRESS <b>Laytonsville, Md.</b>	
25a REC'D BY REGISTRAR DATE <b>MAY 16 '61</b>		25b REGISTRAR'S SIGNATURE <b>Anthony S. Kline</b>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled out by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

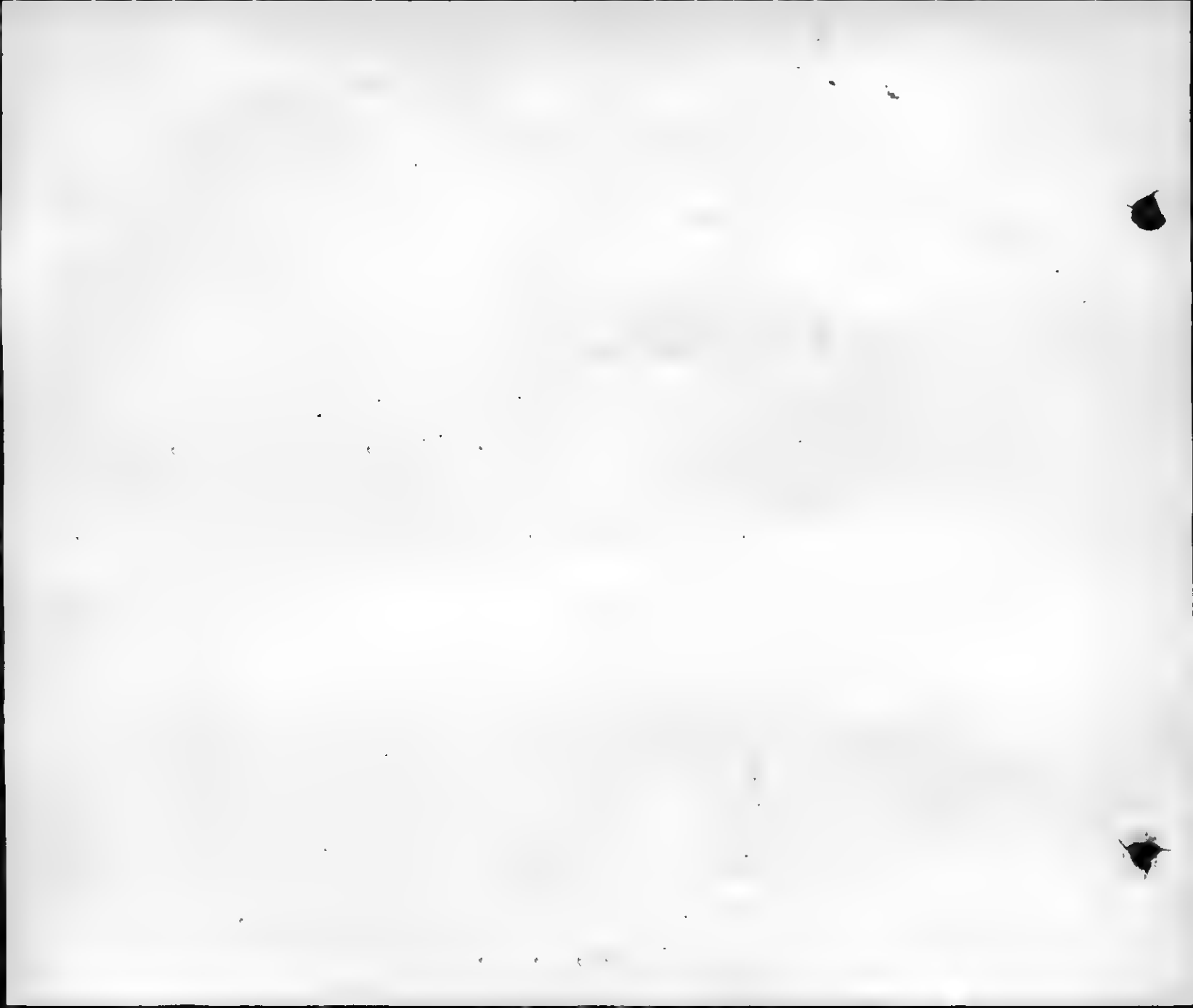
5788

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

65775

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived If institutional on Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Resmor Sanitarium, 5721 Grosvenor La.</b>		d. STREET ADDRESS <b>4118 49th St. N.W.</b>							
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>T.</b> Last <b>Fisher.</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1961</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18 1878</b>		9. AGE (In years last birthday) <b>82</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SECRETARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>A. U.S.</b>			
13. FATHER'S NAME <b>George F. Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Orr</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>John W. Fisher, 4118 49th St, NW</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>222X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>22 mo</b> <b>years</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 24, 1961</b> to <b>May 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 5, 1961</b> , and that death occurred at <b>10:50 PM</b> from the causes and on the date stated above		22a. SIGNATURE <b>C. P. Ryland</b>		M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>5-6-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. P. RYLAND</b>		22d. ADDRESS <b>4400-44th St NW Washington, DC</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/10/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, Iowa</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Bowler's Sons</b>		ADDRESS <b>Washington, D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Plank</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

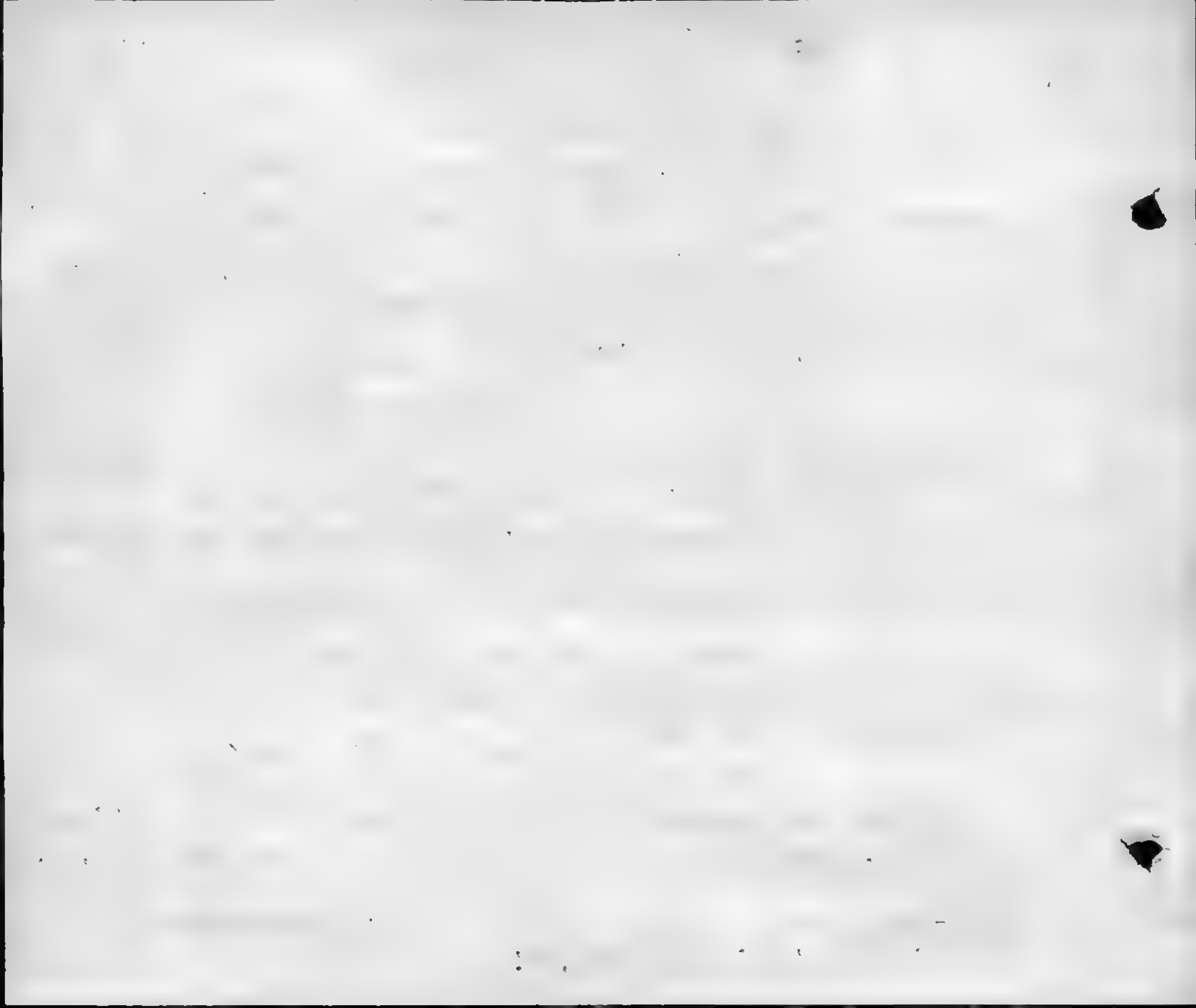
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>16 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. + Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>8600 Greenwood Ave</u> d. STREET ADDRESS <u>Takoma Park 12 Md.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Arthur</u> Middle <u>Garfield</u> Last <u>Fowler</u>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>19</u> Year <u>1961</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6-27-81</u>	
<b>9. AGE</b> (In years last birthday) <u>79 yrs.</u>		<b>10. AGE</b> (In years last birthday) <u>10</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>BURNS</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired machinist</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>BULLARD MFG. Co.</u>			
<b>13. FATHER'S NAME</b> <u>George W. Fowler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>KATHERINE Frances Phelps</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>041-10-0131</u>			
<b>17. INFORMANT</b> <u>W.S. Hosp. Records</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Emphysema ; Chronic lung disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). <u>1 day</u> <u>years</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of form 18)			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20c. (City or town)</b>		<b>20d. (County)</b>	
<b>20e. (State)</b>		<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2-6</u> <u>1957</u> <b>to</b> <u>5/19</u> <u>1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>MAY 19 1961</u> <b>and that death occurred at</b> <u>12:25 P.</u> <b>from the causes and on the date stated above.</b>				<b>22a. SIGNATURE</b> <u>G. Leonard Gold</u>			
<b>22b. PHYSICIAN'S NAME</b> (Type) <u>G. Leonard Gold</u>				<b>22c. ADDRESS</b> <u>8641 Colesville Road, Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit 5/22/61</u>		<b>23b. DATE THEREOF</b> <u>5/22/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lawncroft Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Fairfield Connecticut</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAY 23 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Raymond A. Ziska</u>				<b>25c. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

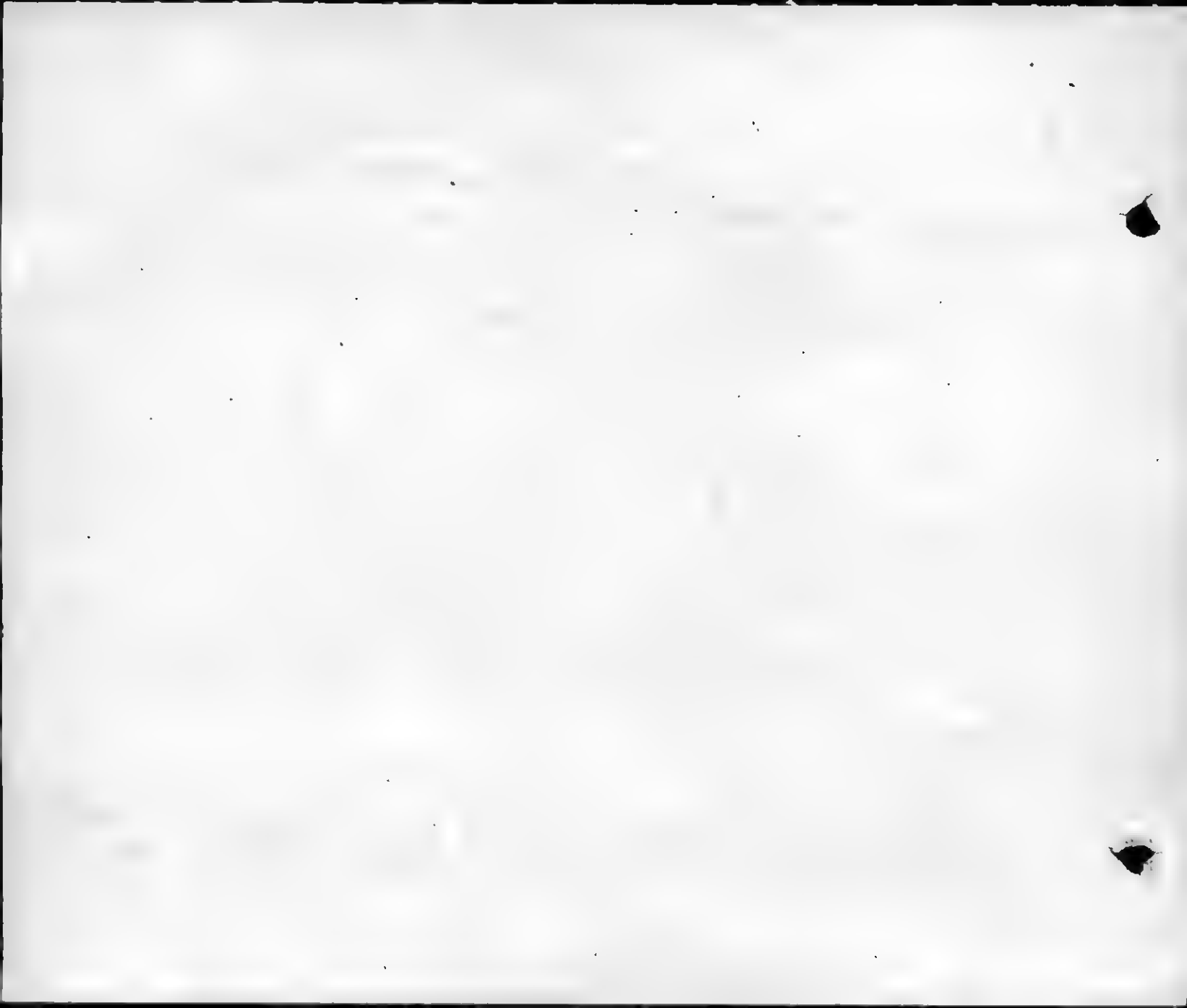
5790

05777

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>11 mo 23 da</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institut on. Residence before admission) a. STATE <u>Montana</u> b. COUNTY <u>Lewis &amp; Clark</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Helena</u> d. STREET ADDRESS <u>None</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Jennie W Graham</u> First Middle Last <b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Jan 31 1898</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>63</u> yrs <b>10. UNDER 1 YEAR</b> <u>4</u> Months <b>11. UNDER 24 HRS.</b> <u>4</u> Days <u>1</u> Hours <u>1</u> Min				<b>4. DATE OF DEATH</b> <u>May 31 1961</u> Month Day Year			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>N. W.</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>England</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>				<b>13. FATHER'S NAME</b> <u>John Whyatt</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Jane Seldon</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <b>16. SOCIAL SECURITY NO</b> <u>None</u> <b>17. INFORMANT</b> <u>James D. Graham, Jr.</u> Address <u>Bethesda, Md</u> <u>6007 Goldsboro Rd</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> DUE TO (b) <u>Carcinomatosis, generalized</u> DUE TO (c) <u>Adenocarcinomatosis of breast left unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 wks</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o m. p m. <u>19</u> <b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>June 1960</u> <b>to</b> <u>31 May 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>27 May 1961</u> <b>and that death occurred at</b> <u>9:15 AM</u> <b>from the causes and on the date stated above</b> <b>22a. SIGNATURE</b> <u>Herbert Martyn Jr</u> M.D. <b>ATTENDING PHYS</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>31 May 61</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>HERBERT MARTYN JR</u> <b>22d. ADDRESS</b> <u>5029 Bethesda Ave</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Bur-Transit</u> <b>23b. DATE THEREOF</b> <u>6/1/61</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mountain View Cem.</u> <b>23d. LOCATION</b> (City, town, or county) (State) <u>Livingston, Montana</u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u> <b>ADDRESS</b> <b>25a. REC'D BY REGISTRAR</b> <u>11/2 61</u> <b>DATE</b> <b>25b. REGISTRAR'S SIGNATURE</b> <u>11/2 61</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

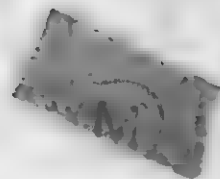
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5791

65778

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4605 Wilwyn Way</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>Box 52</b>	
3. NAME OF DECEASED (Type or print) <b>Clara Angeline Griffith</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <b>May 30 19 61</b> 8. AGE (In years last birthday) <b>94</b> yrs. IF UNDER 1 year IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post mistress, ret</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		11. BIRTHPLACE (Country & State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Porter Griffith</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Virginia Keys</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Ruth G. Veirs-Box 52-Rockville, Md.</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 7-2-1 DUE TO (b) <b>7-2-1</b> Conditions, if any, which gave rise to immediate cause (c) <b>7-2-1</b> DUE TO (c) <b>7-2-1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>cardiovascular accident - cerebral thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>May 29 1961</b> Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 17 1957</b> to <b>May 30 1961</b> , that (I) <b>(me)</b> last saw the deceased alive on <b>May 29 1961</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Stephen C. Cromwell</b> 22c. PHYSICIAN'S NAME (Type) <b>Stephen C. Cromwell</b>		22b. DATE SIGNED <b>5-30-61</b> 22d. ADDRESS <b>Rockville, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6/1/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>JUN 2 '61</b> 25b. REGISTRAR'S SIGNATURE <b>C. S. Kimes</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

05777

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY **MARYLAND**  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b 11 1/2 hrs.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE D.C. b. COUNTY Washington  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington  
d. STREET ADDRESS 3932 Morrison St., NW

3. NAME OF DECEASED (Type or print) Armand Hewllyn Griggs  
First Middle Last

4. DATE OF DEATH MAY 27 1961  
Month Day Year

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH MAY 8, 1909 9. AGE (In years; IF UNDER 1 YEAR last birthday) 52 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meteorologist U.S. Weather Bur. 10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C. 11. BIRTHPLACE (County & State, or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Irving Griggs 14. MOTHER'S MAIDEN NAME ALTA H. SCHINDLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. MR. S. ELIZ. GRIGGS - AS ABOVE 17. INFORMANT MR. S. ELIZ. GRIGGS - AS ABOVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
(a) IMMEDIATE CAUSE Heart Attack  
(b) Conditions, if any, which gave rise to immediate cause Thrombosis  
(c) Cause, stating the underlying cause last. Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/27/1961 to 5/27/1961, that (I) (we) last saw the deceased alive on 5/27/1961, and that death occurred at 1:24 M, from the causes and on the date stated above.

22a. SIGNATURE Armand Griggs 22b. DATE 5/27/61  
22c. PHYSICIAN'S NAME (Type) Armand Griggs M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 23b. DATE THEREOF 5/30/61 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory 23d. LOCATION (City, town or county) (State) Prince Georges County, Maryland

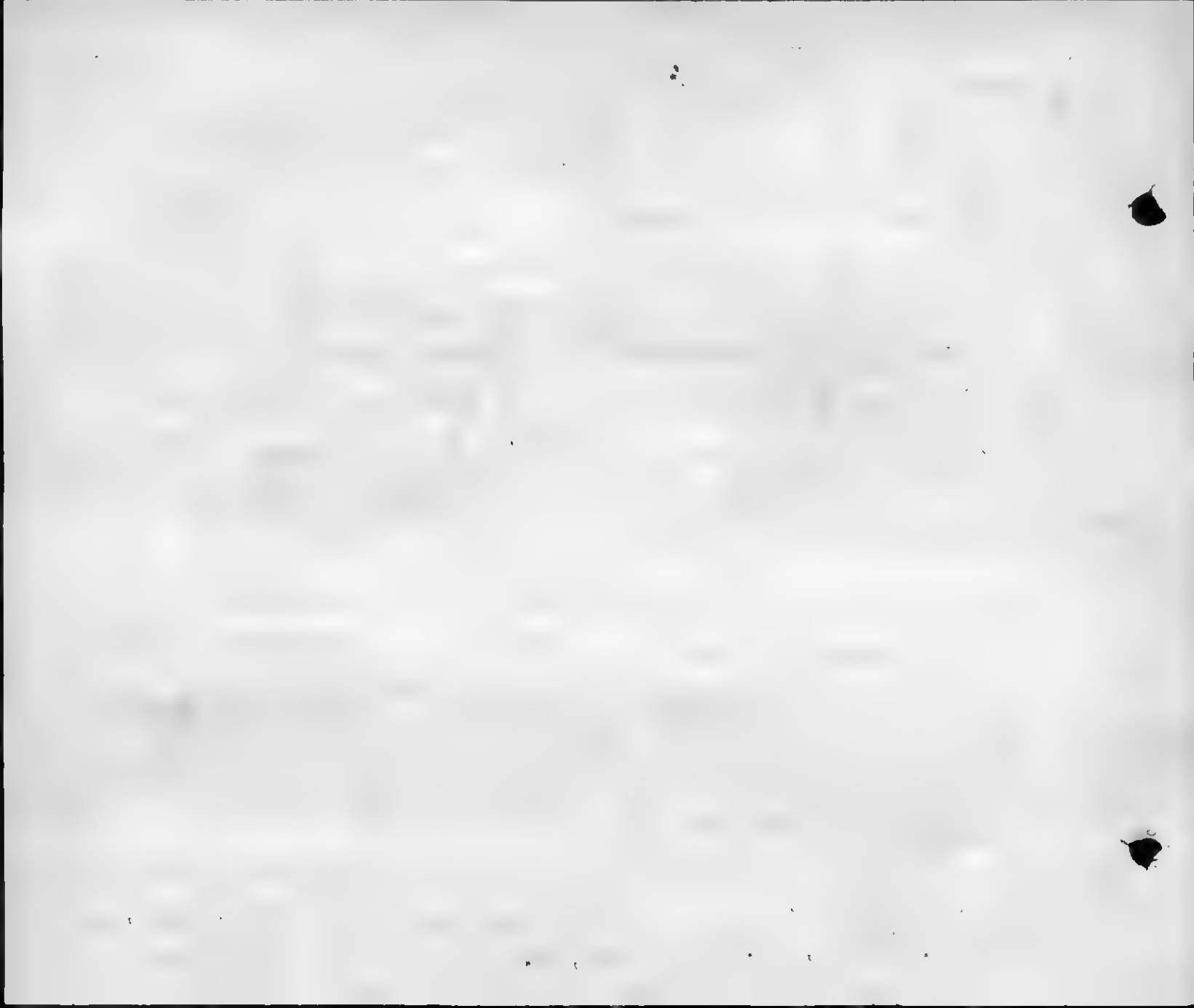
24. FUNERAL DIRECTOR'S SIGNATURE Varner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md. 25a. REC'D BY REGISTRAR Raymond A. Huska 25b. REGISTRAR'S SIGNATURE Arthur S. Kins DATE JUN 6 1961

1

5792

(M)

(I)



5793

## CERTIFICATE OF DEATH

Reg. Dist. No. 65780

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK  
c. LENGTH OF STAY IN 1b 57 days  
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE PENNA b. COUNTY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisburg  
d. STREET ADDRESS 75  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last MARY JANE GROOVER  
4. DATE OF DEATH Month Day Year 5 29 1961

5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 10.26.85 9. AGE (In years last birthday) 77 yrs 10. IF UNDER 1 YEAR: Months 7 Days 3 11. IF UNDER 24 HRS: Hours 7 Min 3

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home-maker 11. BIRTHPLACE (State or foreign country) PENNA 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. Gundy Wolfe 14. MOTHER'S MAIDEN NAME Anna Baker

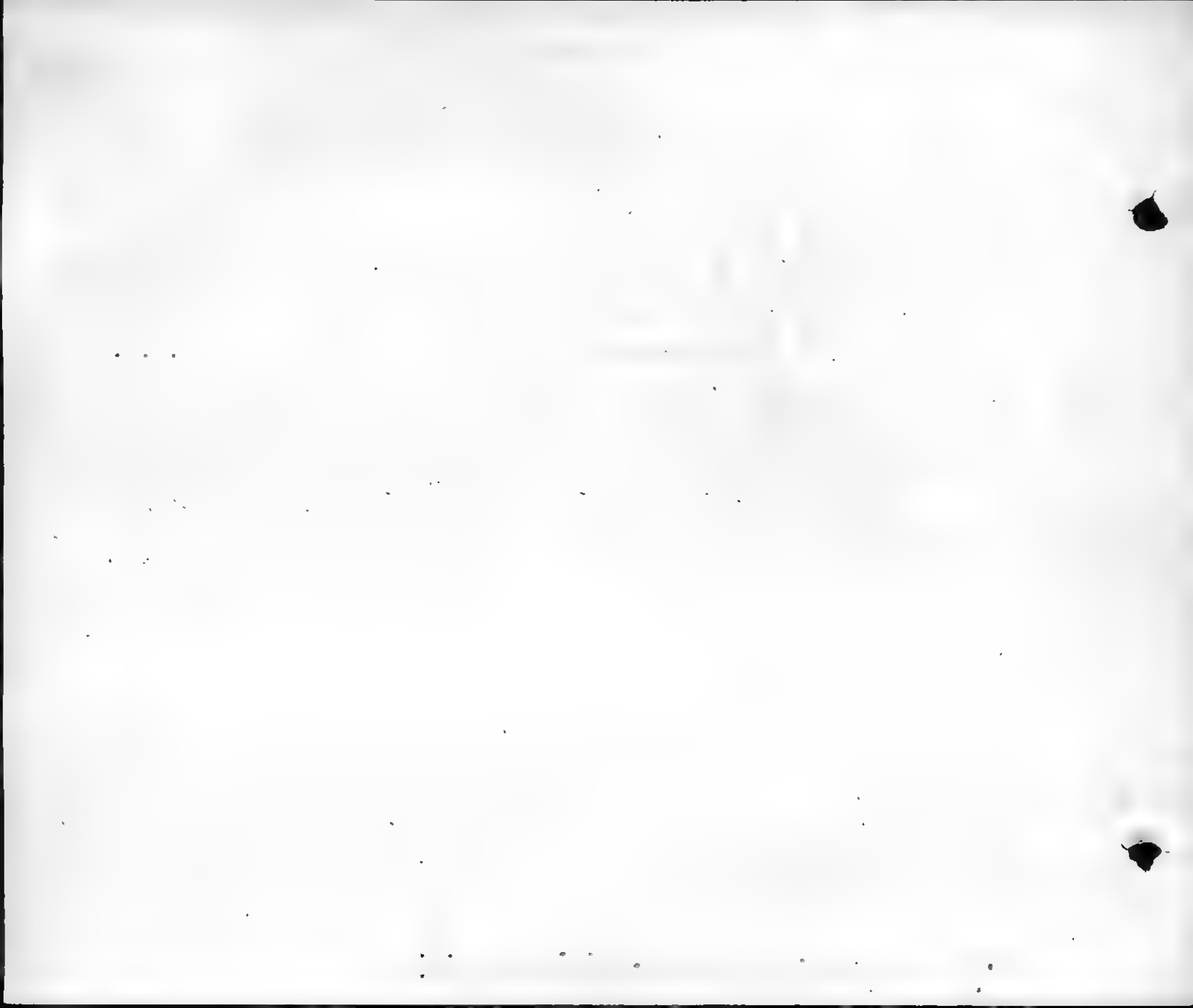
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ☐ If yes, give war or dates of service ☐ 16. SOCIAL SECURITY NO ☐ INFORMANT Address WASHINGTON SANITARIUM & HOSPITAL RECORDS

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Symptoms of Abdominal (Stomach)  
201X DUE TO (b) same symptoms  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) 6 1/4 months  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 1/4 months  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ of work ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
21. I certify that I attended the deceased from 12/30/47, to 5/29/61, that I last saw the deceased alive on 5/29/61, 1961, and that death occurred on 10:25 M, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) 7030 Liverpool Ave. DATE SIGNED 5/29/61  
ACTUAL SIGNATURE Howard T. Morse M.D. Takoma Park Md  
PHYSICIAN'S NAME (Type) HOWARD T. MORSE

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 5/29/1961 22c. NAME OF CEMETERY OR CREMATORY LEWISBURG, PENNSYLVANIA 22d. LOCATION (City, town, or county) (State)  
23. FUNERAL DIRECTOR'S SIGNATURE HYSONG FUNERAL HOME ADDRESS 1300 N. STREET, N.W. 24a. REC'D BY REGISTRAR MAY 31 '61 24b. REGISTRAR'S SIGNATURE W. L. H. HARRIS





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

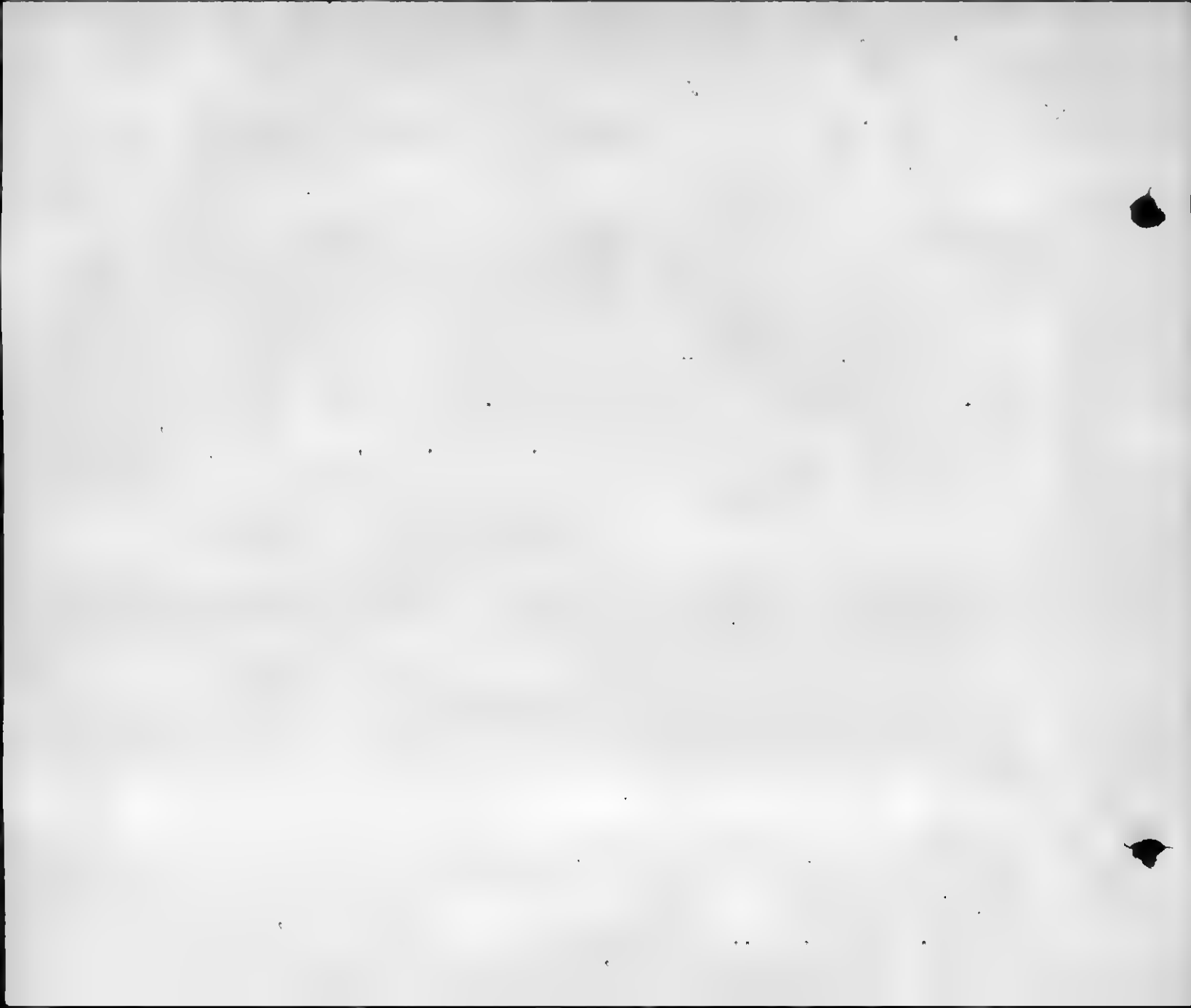
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FOR STATE  
HEALTH DEPT.  
(M)

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
5794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
05781										
1. PLACE OF DEATH a. COUNTY Montgomery			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tahoma Park			c. LENGTH OF STAY in 1b DCA		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington Sanitarium & Hosp			c. LENGTH OF STAY in 1b DCA		d. STREET ADDRESS Arlington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Linda Lee			4. DATE OF DEATH 5 31 1961		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk			9. AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Days Hours Min. 5 23 08 53		10. BIRTHPLACE (State or foreign country) Virginia		11. CITIZEN OF WHAT COUNTRY? USA			
12. FATHER'S NAME Robert Lee Cheely			13. MOTHER'S MAIDEN NAME Linda Hawks		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		15. SOCIAL SECURITY NO. Mr. R. V. Jones - Same Address		16. INFORMANT Brother in law	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SEVERE CORONARY ARTERY ARTERIOSCLEROSIS WITH THROMBOSIS										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										
20f. (City or town) (County) (State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22. ACTUAL SIGNATURE Frank J. Broschanta M.D.										
23. EXAMINER'S NAME (Type) FRANK J. BROSCHANTA										
24. DATE SIGNED 5-31-61										
25. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										
26. DATE THEREOF 6-3-61										
27. NAME OF CEMETERY OR CREMATORY COLUMBIA GARDENS										
28. LOCATION (City, town, or country) ARLINGTON VA										
29. FUNERAL DIRECTOR Ives Funeral Home, Inc.										
30. ADDRESS ARLINGTON, VA										
31. REC'D BY REGISTRAR										
32. REGISTRAR'S SIGNATURE Arthur S. Kraus										
DATE JUN 5 '61										



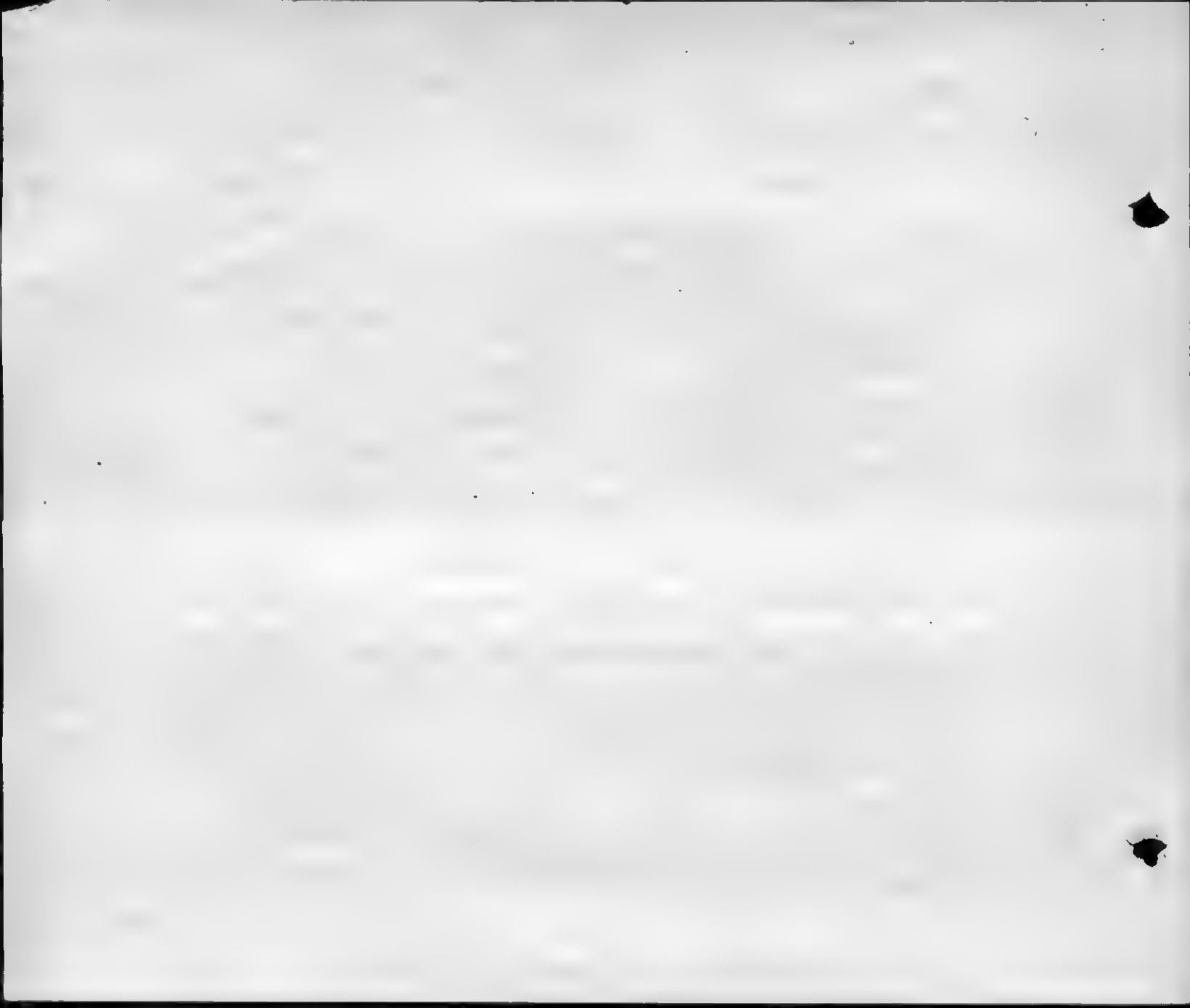
YS. AISME  
SM 9/60

Arthur J. Kravitz



VS. A15ME  
5M 9/60

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>2 wks</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>723 Boundary Ave</u>													
3. NAME OF DECEASED (Type or print) <u>Samuel Homer Hamblin</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9- - 1911</u>		9. AGE (In years last birthday) <u>49</u>		10. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va (Pulaski County)</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO <u>224-10-5650</u>		17. INFORMANT <u>MRS HELEN NESTER HAMBLIN (wife)</u> <u>c/o Devilbliss Funeral Home, Radford Va</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead on floor at home</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-21-61</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/24/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SIFFORD CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>PULASKI COUNTY, VA.</u>		23. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc</u> ADDRESS <u>8134 S. S. West</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

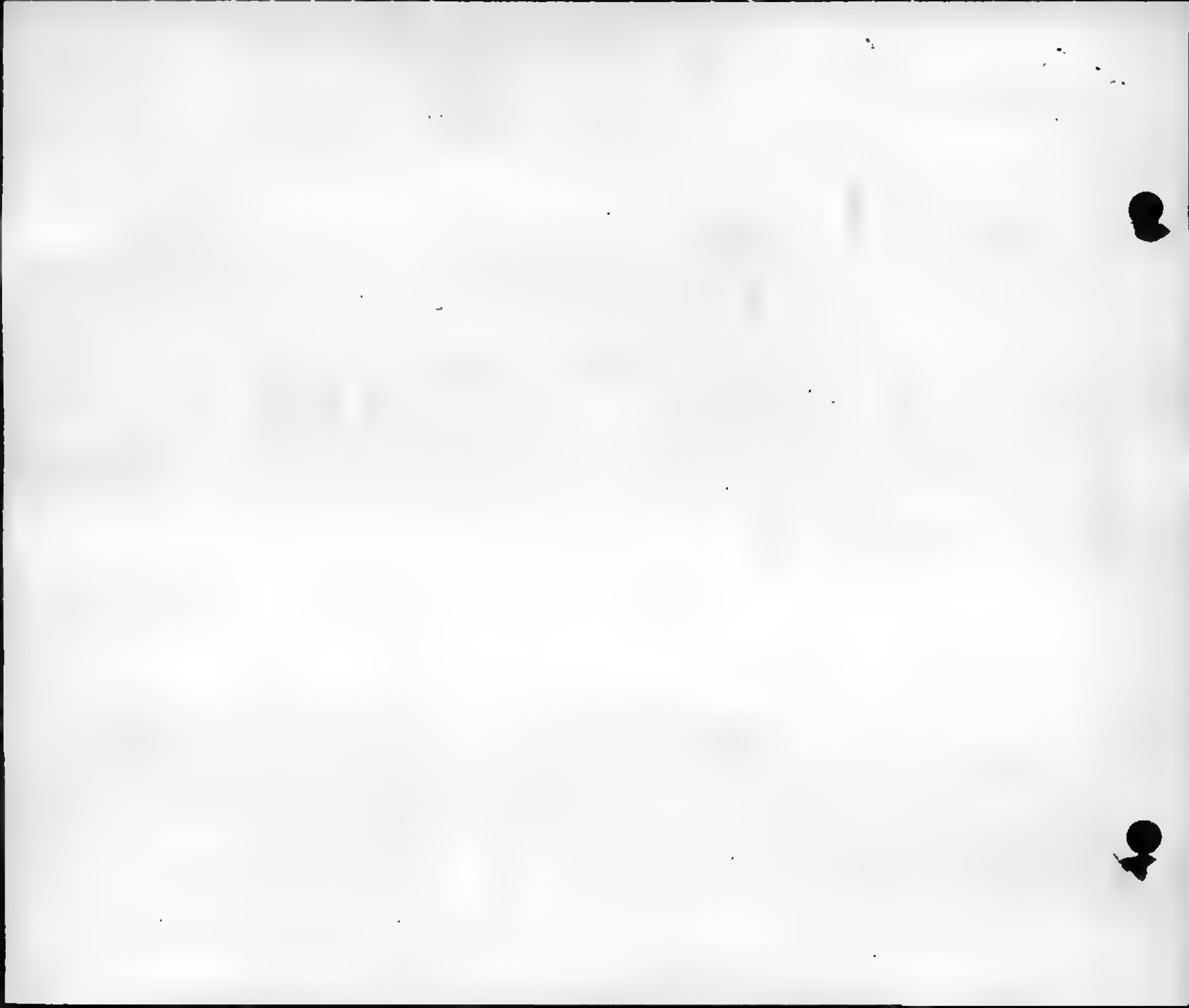
5797

05784

**(M)**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Harrison</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clarksburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4727 Boiling Brook Pkwy.</b>		d. STREET ADDRESS <b>25X-1</b>	
3. NAME OF DECEASED (Type or print) First <b>Lot</b> Middle <b>P</b> Last <b>Hansford</b>		4. DATE OF DEATH Month <b>May</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1877</b>
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>6</b> Hours <b></b> Min <b></b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gas Company</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Francis H. Hansford</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Barnette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Louise Osborne-Daughter-same 1d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>PROSTATIC HYPERTROPHY</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS</b>  <b>2 YEAR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <b></b> Day <b></b> Year <b>19</b> Hour <b></b> o. m. <b></b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 8</b> 1961, to <b>MAY 24</b> 1961, that (I) <del>was</del> lost saw the deceased alive on <b>MAY 24</b> 1961, and that death occurred at <b>8:27A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edward A. Beeman</b>		22b. DATE SIGNED <b>MAY 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD A. BEEMAN</b>		22d. ADDRESS <b>10620 GEORGIA AVE. SILVER SPRING, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>	23b. DATE THEREOF <b>5/27/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Elks View Masonic Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Clarksburg, W. Va.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>MAY 25 '61</b>	
ADDRESS <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>J. L. S. Hines</b>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

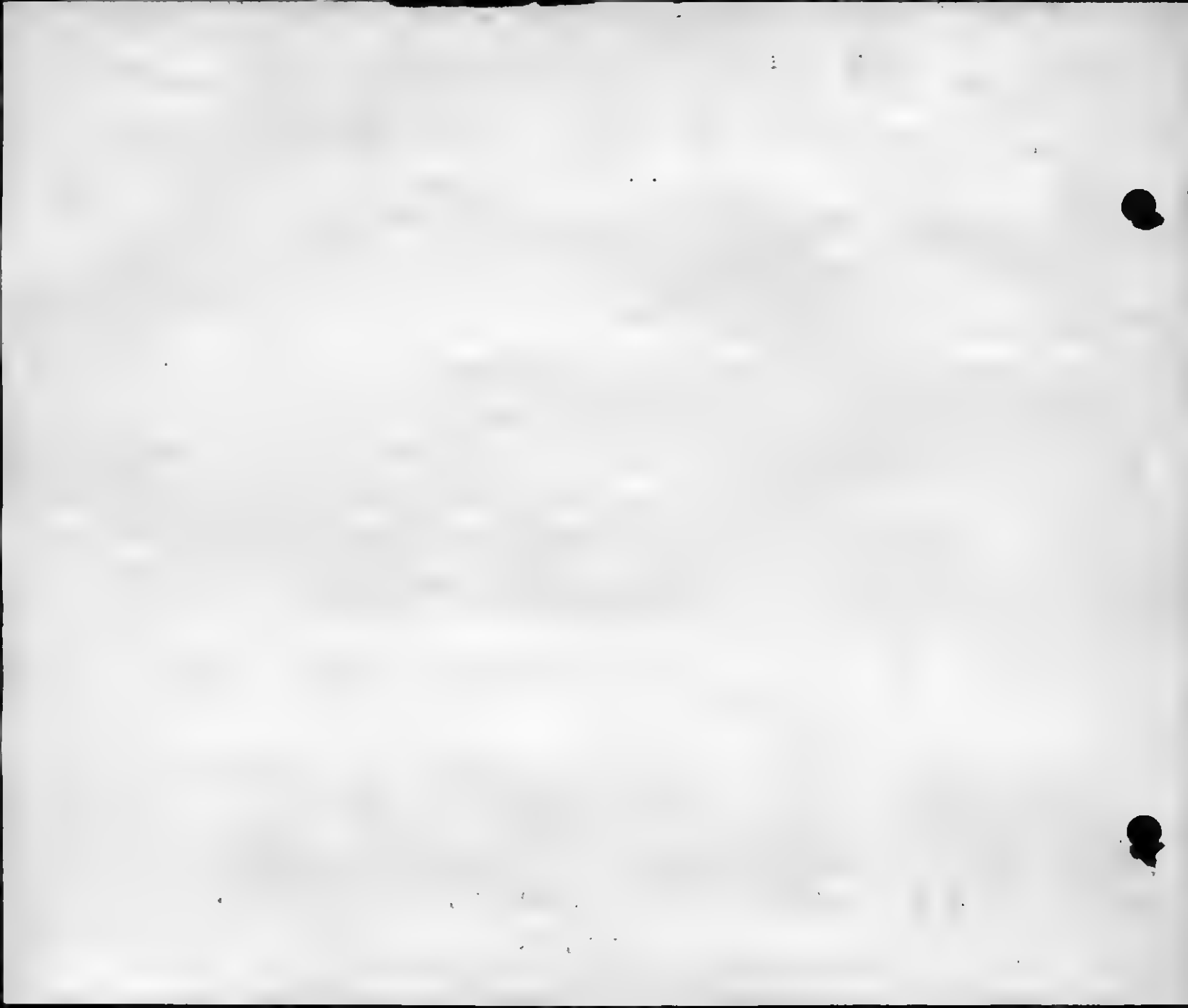
**5798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05785

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leithersin  
c. LENGTH OF STAY IN MD  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calin John  
d. STREET ADDRESS 6914 Seven Locks Road

3. NAME OF DECEASED (Type or print) Thomas Hart  
First Middle Last  
4. DATE OF DEATH May 27 1961  
Month Day Year  
5. SEX Male  
6. COLOR OR RACE Col  
7. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH May 27 1920  
Month Day Year  
9. AGE (in years last birthday) 41 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (State or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? U.S.A.  
13. FATHER'S NAME Thomas Hart  
14. MOTHER'S MAIDEN NAME Mary Harris  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Dorothy Hart (Wife) Same as above Address  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.4 DUE TO Acute myocardial insufficiency  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial hypertrophy  
(c) Cor pulmonale  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I  
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 6/5/61  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
ACTUAL SIGNATURE Frank J. Brochart M.D.  
EXAMINER'S NAME (Type) Frank J. Brochart  
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
22b. DATE THEREOF 6/5/61  
22c. NAME OF CEMETERY OR CREMATORY Arlington National.  
22d. LOCATION (City, town, or country) (State) Arlington, Va.  
23. FUNERAL DIRECTOR Robert L. Surwden ADDRESS Rockville, Md.  
24a. REC'D BY REGISTRAR JUN 7 '61  
24b. REGISTRAR'S SIGNATURE William L. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

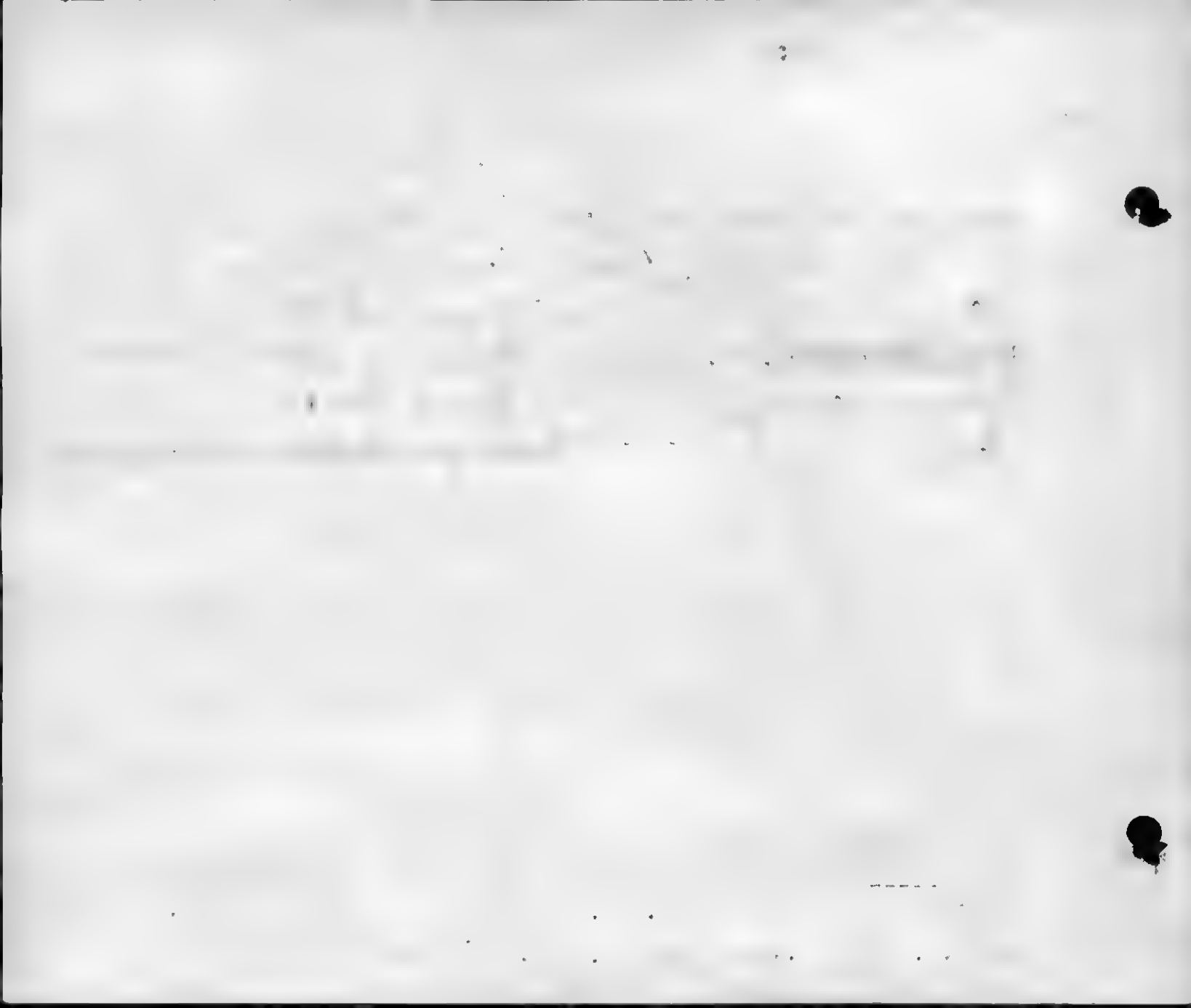
VR A15 (4)  
15M 9/60

5795

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65780

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>15 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>6900 23rd Avenue</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mr. James Moore Hartley</u>		<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>5</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>February 12, 1881</u>	
<b>9. AGE</b> (In years, last birthday) <u>80</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>5</u> Days <u>19</u> Hours <u>61</u> Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Bank Clerk, Nat. Bk. of Wash.</u>		<b>12. C. CITIZEN OF WHAT COUNTRY?</b> <u>District of Columbia U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Joseph Hartley</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Cook</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-22-1690</u>	
<b>17. INFORMANT</b> <u>Washington Sanitarium and Hospital Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Compensated heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic pyelonephritis</u> (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 weeks</u> <u>5 yrs</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/21</u> <b>1961</b> <b>to</b> <u>5/4</u> <b>1961</b> , <b>that (I) (we) last saw the deceased alive on</b> <u>5/4</u> <b>1961</b> , <b>and that death occurred at</b> <u>5:45 PM</u> , <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Wayne Clickfield</u> <b>22b. DATE SIGNED</b> <u>5/5/61</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WAYNE CLICKFIELD</u>		<b>22d. ADDRESS</b> <u>6826 Riggs Rd. Hyattsville</u>	
<b>23a. BURIAL, CREMATION, or other disposition (Specify)</b> <u>burial</u>		<b>23b. DATE THEREOF</b> <u>5/9/61</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Nat. Mem. Park Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> <u>Falls Church, Virginia</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		<b>25. REC'D BY REGISTRAR</b> <u>MAY 8 '61</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Saint + Hospt.</u>				2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4840 Ft. Totten dr. N.E.</u>			
3. NAME OF DECEASED (Type or print) <u>Fern</u> <u>Collie</u> <u>Harvey</u> First Middle Last		4. DATE OF DEATH Month <u>5</u> Day <u>31</u> Year <u>1961</u>		5. SEX <u>Fe.</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-1907</u>		9. AGE (in years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S.W.F.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Spencer Abbott</u>				14. MOTHER'S MAIDEN NAME <u>Fern Prather</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Joseph C. Harvey</u> <u>Husband</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic coma</u> 2-6 OX DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diabetes mellitus</u> (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/30/61</u> , 19 <u>61</u> , to <u>5/31/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/31/61</u> , 19 <u>61</u> , and that death occurred at <u>9:55</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>A.W. Smith</u>				22b. DATE SIGNED <u>5/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.W. SMITH</u>				22d. ADDRESS <u>13018 GEORGIA AVE W HEATON, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>St. Thomas Co</u>				25a. REC'D BY REGISTRAR <u>2901 1450 NW</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				DATE <u>JUN 1 '61</u>			

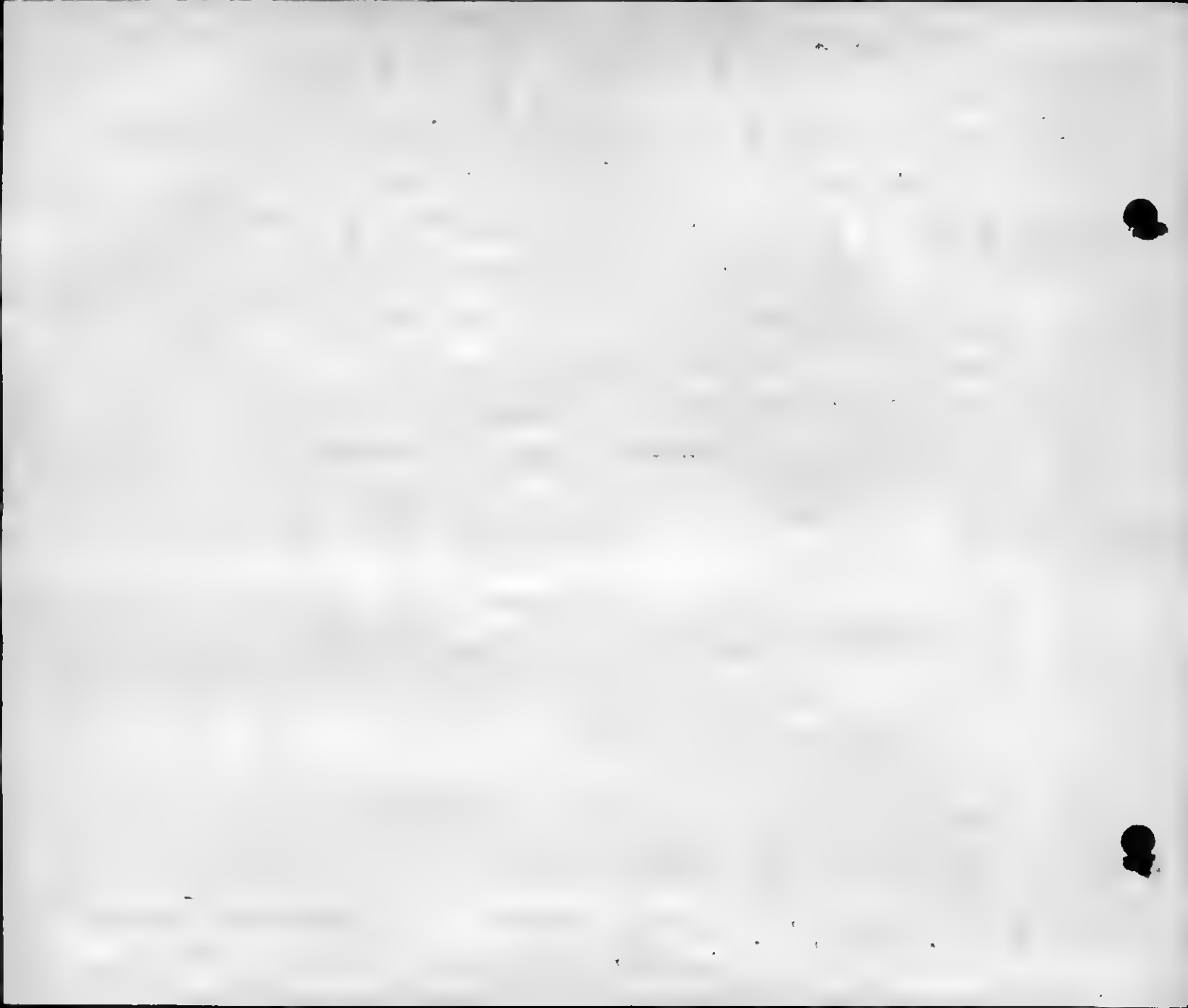












TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician and completely filled by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

5803

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05790

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Derwood, R.F.D. #1</b>		c. LENGTH OF STAY IN 1b <b>7 Months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammons Nursing Home</b>		d. STREET ADDRESS <b>Highland, Md</b>	
3. NAME OF DECEASED (Type or print) First <b>Franklin</b> Middle <b>Holland</b> Last <b>Holland</b>		4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1899</b>
9. AGE (In years last birthday) <b>62</b> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Grafton Holland</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth White</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO <b>Mrs Laura Wilson Highland, Md (Sister)</b>	
17. INFORMANT <b>Mrs Laura Wilson Highland, Md</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>C.V.A.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> to <b>5/19</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> 19 <b>61</b> , and that death occurred at <b>4:45</b> P.M. from the causes and on the date stated above			
22a. SIGNATURE <b>Luciano I. Leal</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Luciano I. Leal</b>		22d. ADDRESS <b>Garthensburg Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/23/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hopkins Chapel Cem</b>		23d. LOCATION (City, town, or county) (State) <b>Highland, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Shauden</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 29 '61</b>	
ADDRESS <b>Rockville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5804

05791

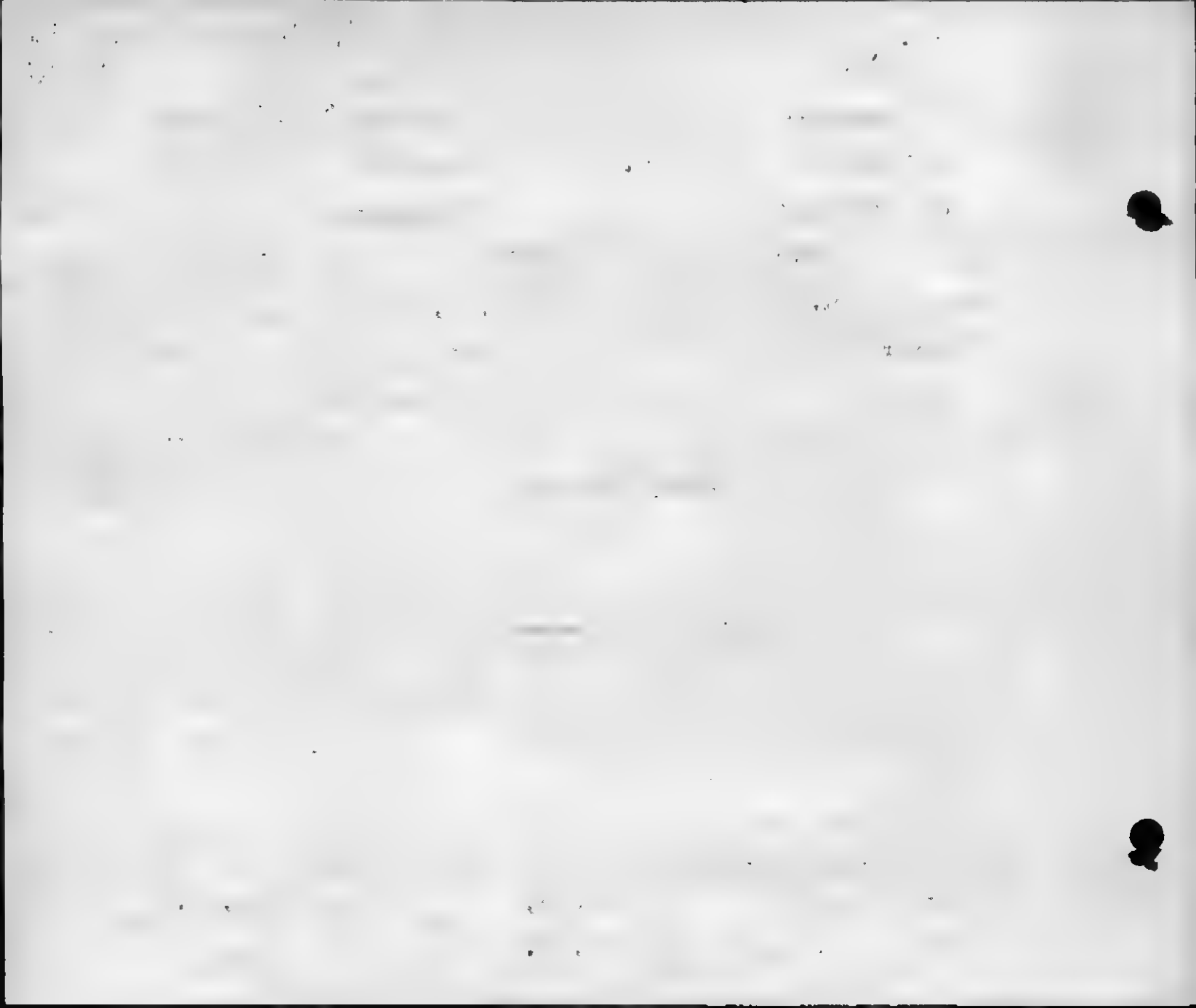
1  
FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b <b>hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4004 Hampden St</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Howard</b>		4. DATE OF DEATH <b>May 23</b>		5. SEX <b>male</b>	
6. COLOR OR RACE <b>col.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 20, 1900</b>	
9. AGE (In years last birthday) <b>60</b> yrs		10. BIRTHPLACE (State or foreign country) <b>MA</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
12. FATHER'S NAME <b>Unknown</b>		13. MOTHER'S MAIDEN NAME <b>Carrie Hopkins</b>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
15. SOCIAL SECURITY NO <b>1201</b>		16. INFORMANT <b>Rose Nickens, 4003 Hampden St., Kensington, Md.</b>		17. ADDRESS <b>4003 Hampden St., Kensington, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>					
DUE TO (b) <b>7201</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <b>History of previous heart disease</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>History of previous heart disease</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Address (Street, city, town, or county)					
DATE SIGNED <b>5/23/61</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify)					
22b. DATE THEREOF <b>5/27/61</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial,</b>					
22d. LOCATION (City, town, or country) (State) <b>Sandy Spring, Md.</b>					
23. FUNERAL DIRECTOR <b>Robert L. Surod</b>					
ADDRESS <b>Rockville, Md.</b>					
24a. REC'D BY REGISTRAR <b>JUN 7 '61</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

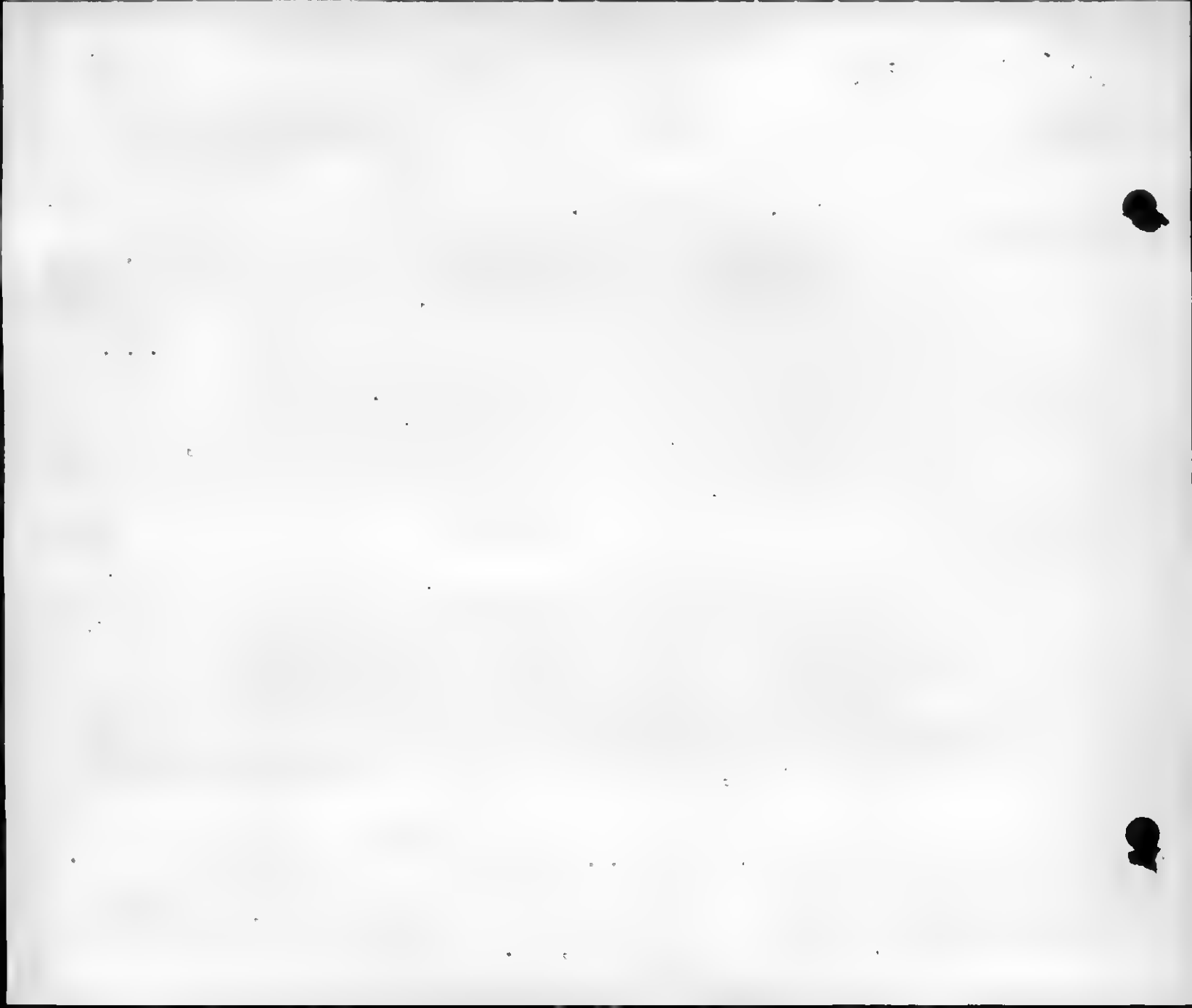
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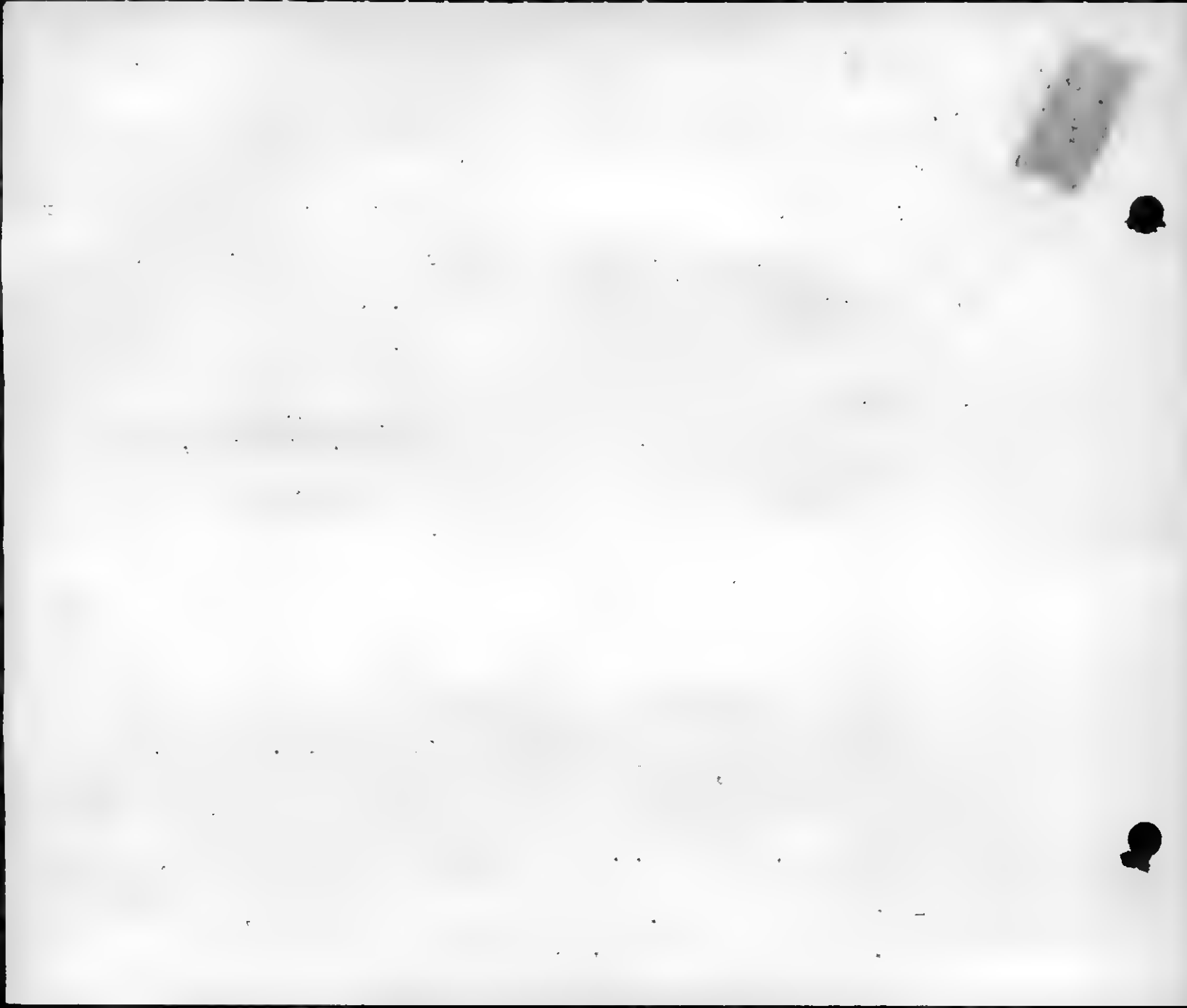


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M  
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2  
1  
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be by the hospital or attending physician on.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 11, MARYLAND

5806  
CERTIFICATE OF DEATH  
ITEM 100 5/9/61.cac 05794

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>68 days</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Whippany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whippany</b> d. STREET ADDRESS <b>130 Parsippany Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Edward Joseph Izykowiec</b>		4. DATE OF DEATH Month Day Year <b>May 2, 19 61</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 25, 1926</b>
9. AGE (In years last birthday) <b>35</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>35</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New Jersey</b>	
11 BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Izykowiec</b>		14 MOTHER'S MAIDEN NAME <b>Anna Sharry</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 11, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Open heart surgery with total replacement of aortic valve</b> DUE TO <b>Aortic valvular insufficiency</b> (b) DUE TO <b>Subacute bacterial endocarditis and Rheumatic heart disease</b> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4-5 months</b> <b>20 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-5 months</b> <b>20 years</b>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>February 23, 19 61</b> , to <b>May 2, 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 2, 19 61</b> , and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.		22a SIGNATURE <b>James L. Talbert</b> M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> <b>5-2-61</b> 22b ADDRESS <b>The Clinical Center</b> <b>National Institutes of Health,</b> <b>Bethesda 11, Maryland</b>	
22c PHYSICIAN'S NAME (Type) <b>James L. Talbert M.D.</b>		22d ADDRESS <b>The Clinical Center</b> <b>National Institutes of Health,</b> <b>Bethesda 11, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 5/3/61</b>		23b DATE THEREOF <b>5/3/61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Whippany, New Jersey</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>		DATE <b>MAY 4 '61</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, it is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5807

05795

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN TB <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium r hsp. Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>205 Dogwood Ave</u> d. STREET ADDRESS <u>Takoma Park</u>	
3. NAME OF DECEASED (Type or print) <u>Novella Celestia James</u>		4. DATE OF DEATH <u>5 30 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-15-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George W. Rison</u>		14. MOTHER'S MAIDEN NAME <u>Alice M. Mattingly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>1204</u> (c) <u>Due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Collapsed in bath room at home</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year <u>19 61</u>		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery Washington, D.C.</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co. Washington 9, D.C.</u>		24. REC'D BY REGISTRAR <u>JUN 1 '61</u>	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

NAME (Type)

Frank J. Brosch

FRANK J. Brosch

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

5-30-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

burial

22b. DATE THEREOF

6/1/61

22c. NAME OF CEMETERY OR CREMATORY

Congressional Cemetery Washington, D.C.

22d. LOCATION (City, town, or country)

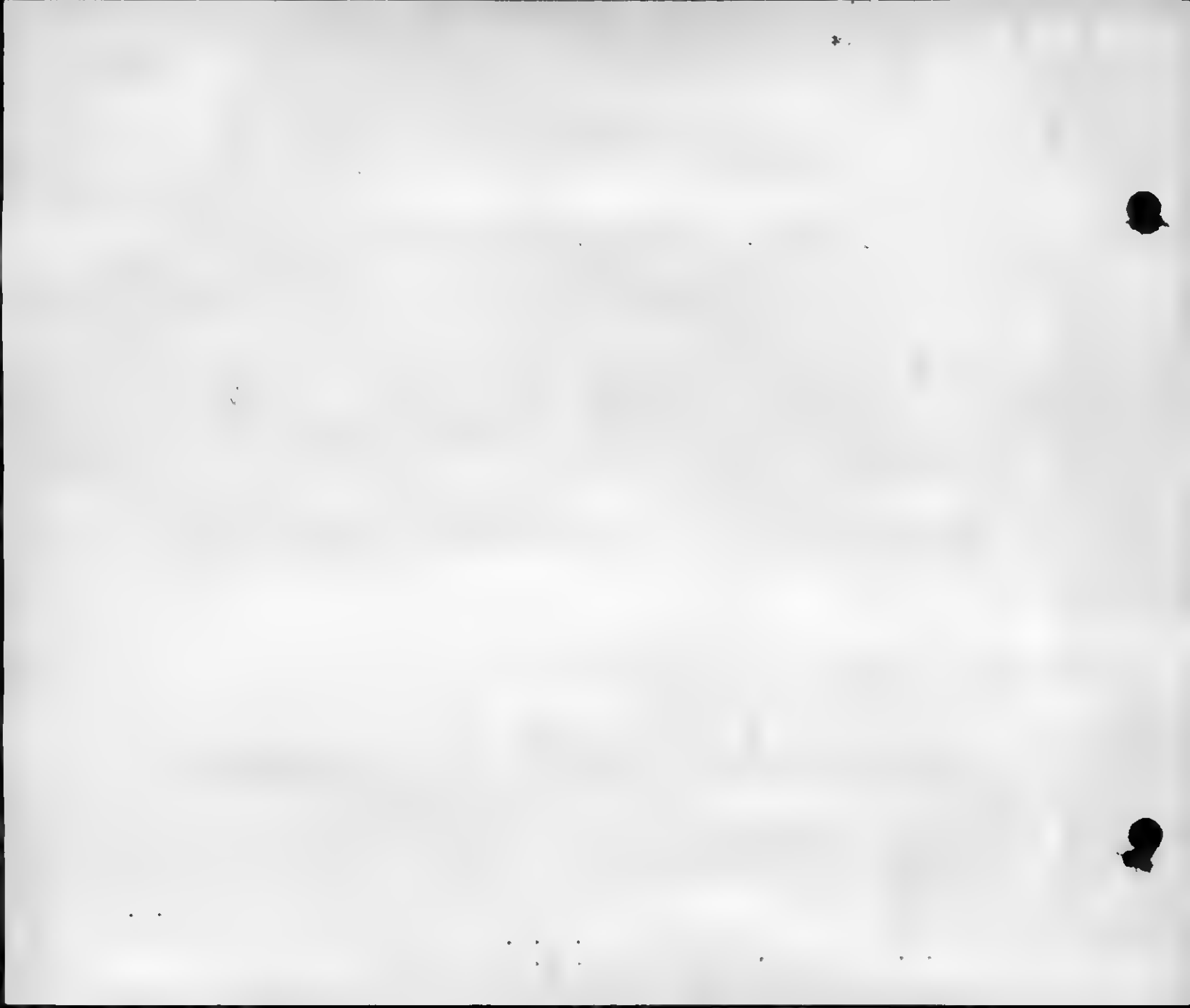
(State)

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

JUN 1 '61

William E. Hines



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

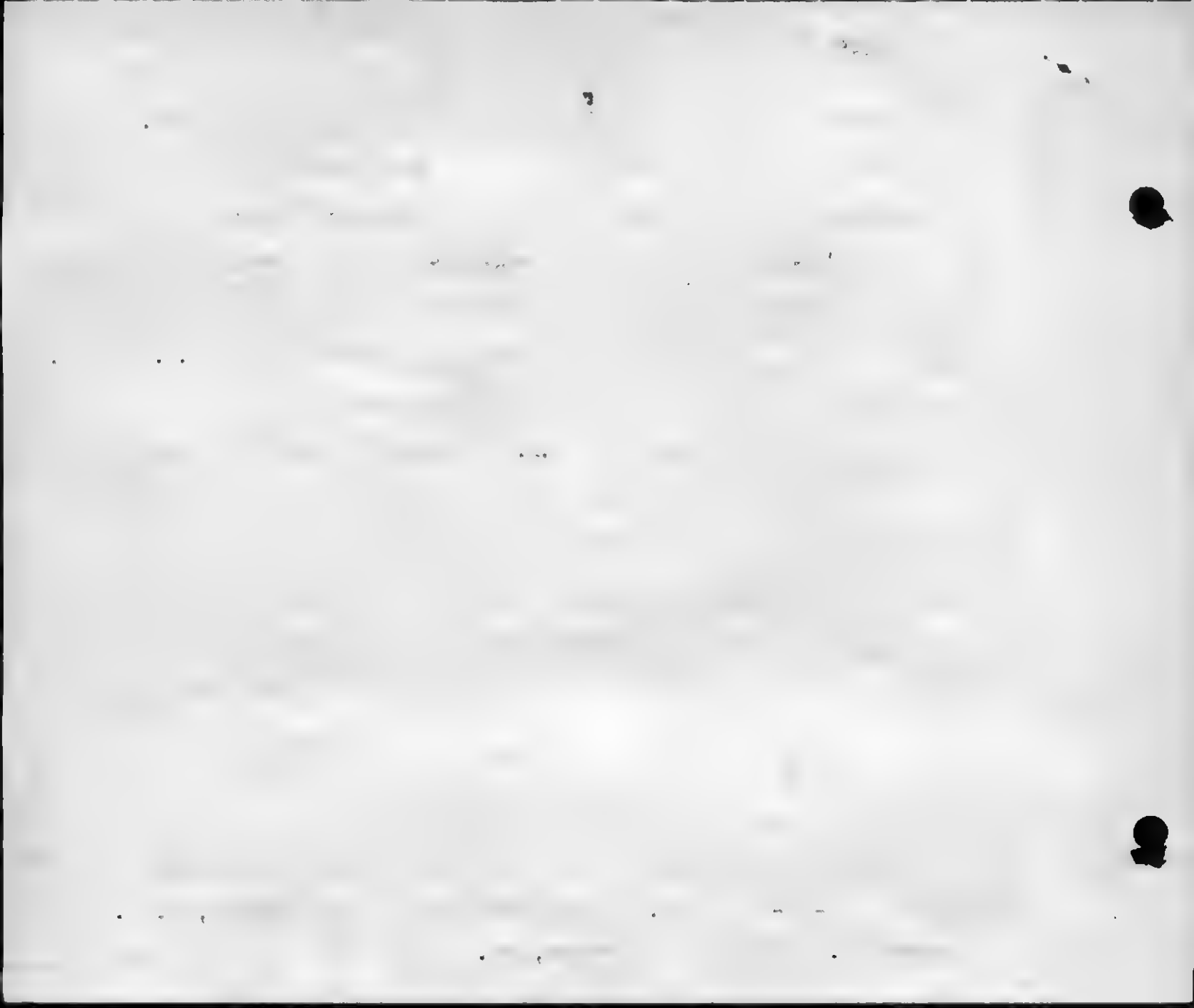
## CERTIFICATE OF DEATH

5808

05796

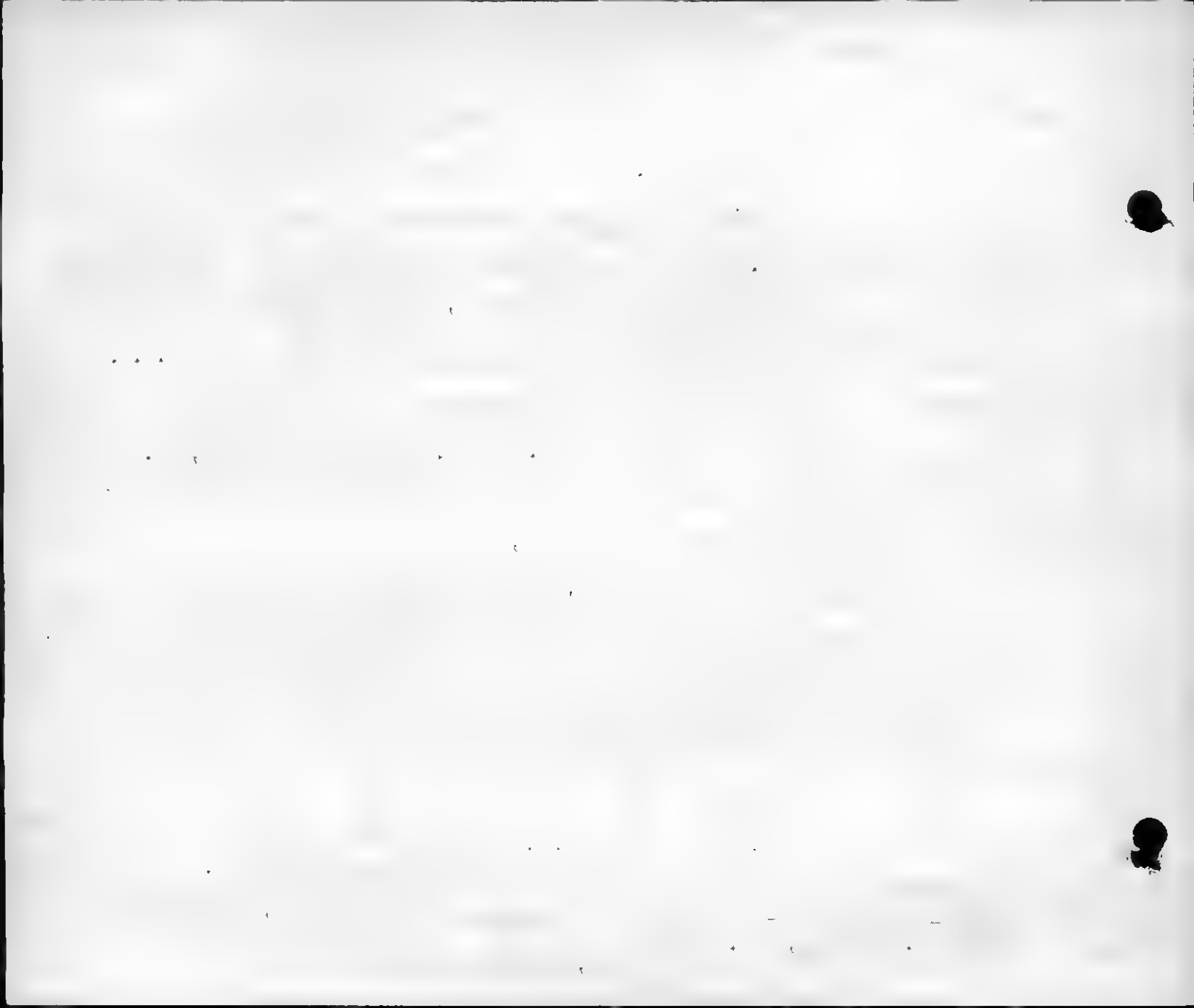
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b <b>3 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Mont.</b>		c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Chevy Chase 15</b>		d. STREET ADDRESS <b>7104 Beechwood Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Nonna</b>		First		Middle <b>T</b>		Last <b>JARVIS</b>		4. DATE OF DEATH Month <b>May</b>		Day <b>15</b>		Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>3/17/83</b>		8. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>15</b>		Days <b>19</b>		Hours <b>61</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State or foreign country) <b>Waterville, Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A 50 yrs.</b>		13. FATHER'S NAME <b>John Oulihan</b>		14. MOTHER'S MAIDEN NAME <b>Joanna Foley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>W.F. Jarvis (son) Bloomfield Hills, Mich</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ix</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e) <b>Tuberculosis</b>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from <b>Feb 5</b> 19 <b>61</b> , to <b>May 15</b> 19 <b>61</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>May 14</b> 19 <b>61</b> , and that death occurred at <b>6:15</b> A.M. from the causes and on the date stated above.		22a. SIGNATURE <b>J. R. Ruddy</b>		22b. DATE SIGNED <b>5-15-61</b>		22c. PHYSICIAN'S NAME (Type) <b>J. R. Ruddy</b>		22d. ADDRESS <b>3701 Leland ST Chevy Chase Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>6-17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 19 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. Evans</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.









# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

05798

*Wheaton Nursing Home*

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHEATON  
c. LENGTH OF STAY IN 1b 1 day  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE MD. b. COUNTY \_\_\_\_\_  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING  
d. STREET ADDRESS 2102 HILDAOSE DRIVE

3. NAME OF DECEASED (Type or print)  
First Middle Last  
HARRY ALBERT JOHNSON

4. DATE OF DEATH MAY 1, 1961

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH APRIL 5, 1890

9. AGE (in years last birthday) 71 yrs. IF UNDER 1 YEAR: Months \_\_\_\_\_ Days \_\_\_\_\_ Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Claim Adjuster 10b. KIND OF BUSINESS OR INDUSTRY Capital Product 11. BIRTHPLACE County & State or foreign country St. Louis, Mo. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HENRY C JOHNSON 14. MOTHER'S MAIDEN NAME VIRGINIA CORR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT KATHERINE F JOHNSON 2102 Hildaose Dr. Address \_\_\_\_\_

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Pneumonia  
DUE TO \_\_\_\_\_  
Conditions, if any, which gave rise to immediate cause (b) Bronchogenic carcinoma  
(c), stating the underlying cause last, DUE TO \_\_\_\_\_  
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Longestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) \_\_\_\_\_ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) \_\_\_\_\_

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 \_\_\_\_\_ 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 20f. (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

21 I certify that (I) (the hospital) attended the deceased from August 1, 1957 to May 1, 1961, that (I) (the) last saw the deceased alive on May 1, 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE Samuel T. Hendrick 22b. DATE SIGNED May 1, 1961  
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type) \_\_\_\_\_ 22d. ADDRESS 927 Potomac Drive Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-4-61 23c. NAME OF CEMETERY OR CREMATORY Libelanden Church 23d. LOCATION (City, town or county) Lanier Va (State) \_\_\_\_\_

24. FUNERAL DIRECTOR'S SIGNATURE Edgar E. ... ADDRESS 4812 ... 25a. REC'D BY REGISTRAR MAY 5 '61 25b. REGISTRAR'S SIGNATURE Charles S. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be used by the hospital or attending physician. TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

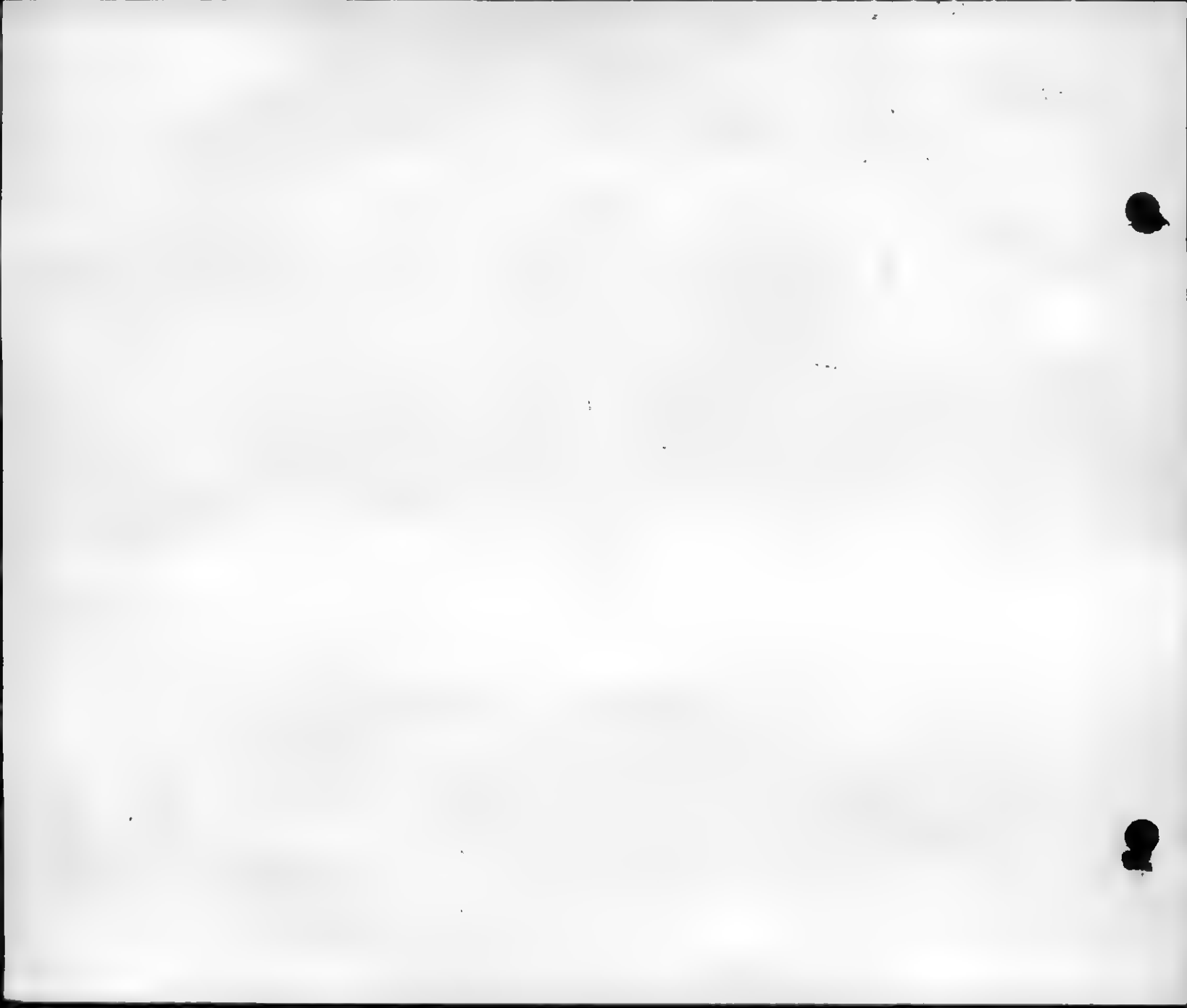
CERTIFICATE OF DEATH

5811

Items 7 & 12 fill in G-sub 5/8/61 ink

65291

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>1830 R. St.</u> COUNTY <u>MD.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Hospital-Sanitarium</u>				d. STREET ADDRESS <u>5721 Grosvenor Lane</u>			
3. NAME OF DECEASED (Type or print) <u>Samuel A. Johnson</u>				4. DATE OF DEATH <u>May 2 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22 1870</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State of foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frederick Johansen</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Astrid C. Highfield</u> Address <u>Washington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>67</u> DUE TO <u>HYPOTENSION + RESPIRATORY ARREST</u>				<u>3 MINS.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO <u>UREMIA</u>				<u>6 MONTHS.</u>			
(c) DUE TO <u>CHRONIC PYELONEPHRITIS</u>				<u>12 YEARS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROSTATIC CARCINOMA; GENERALIZED ARTERIOSCLEROSIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 14 1956</u> to <u>MAY 2 1961</u> , that (I) (we) last saw the deceased alive on <u>APRIL 30 1961</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph V. Connor</u> M.D.				22b. DATE <u>May 2 1961</u> SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, M.D.</u>				22d. ADDRESS <u>9420 OLD GEORGETOWN RD BETHESDA MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>PP G. C. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. L. Lumbie</u> ADDRESS <u>1400 Chapin St. NW Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAY 3 '61</u> DATE		25b. REGISTRAR'S SIGNATURE <u>William S. Kneen</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

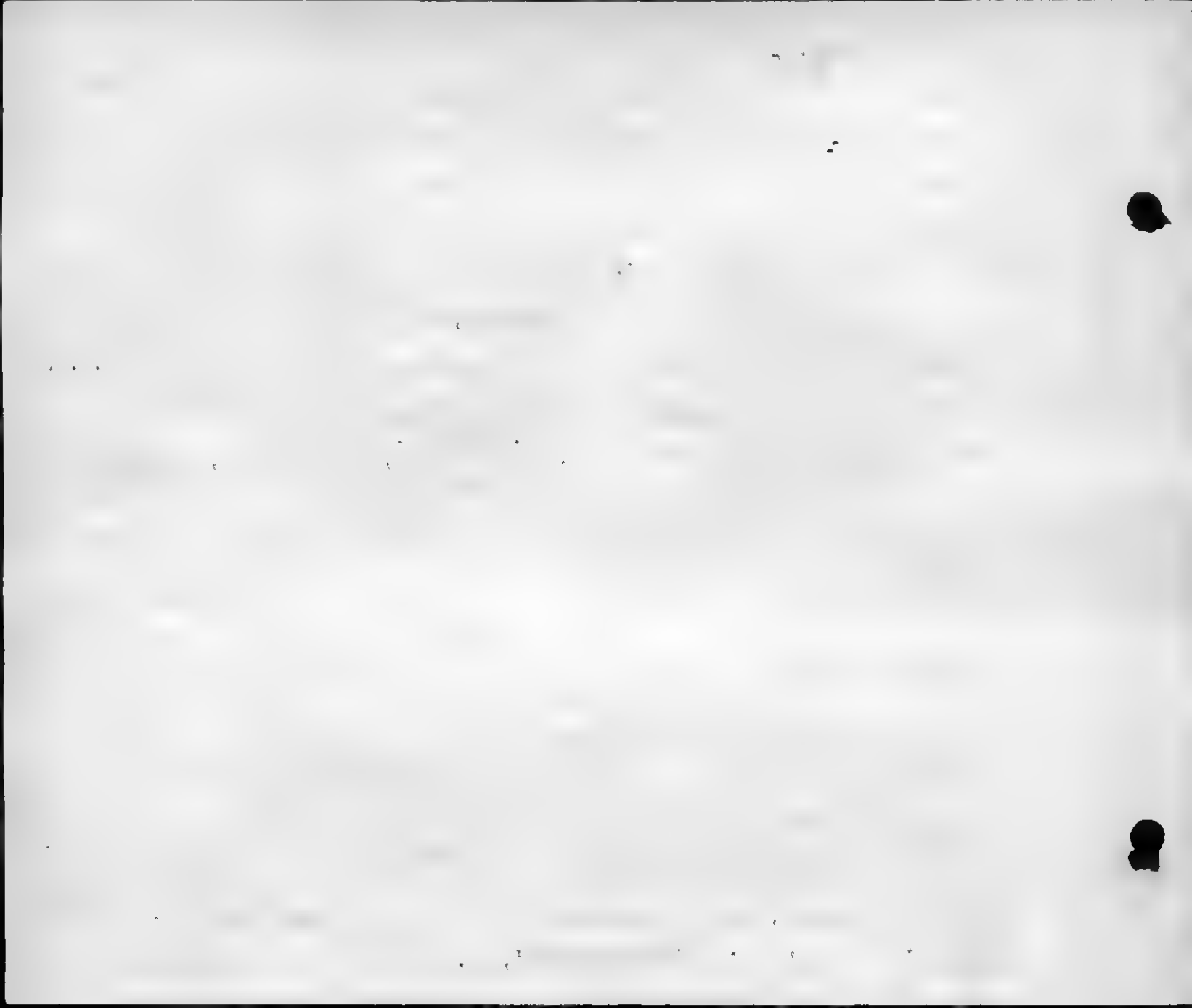
## CERTIFICATE OF DEATH

5812

05840

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY N 15 <u>P.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sam. &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10033 Dallas Ave.</u>							
<b>3. NAME OF</b> [Type or print] <u>Anna E. Johnston</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>19</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>							
<b>8. DATE OF BIRTH</b> <u>May 26, 1882</u>		<b>9. AGE</b> (In years last birthday) <u>78</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours	Min.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months	Days										
Hours	Min.										
<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Ireland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Mrs. Harold D. Brockwell</u>							
<b>18. CAUSE OF DEATH</b> (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> (b) <u>Hypertension</u> (c) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Interval between onset and death 10 yr</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>											
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)											
<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 15, 1961</u> <b>to</b> <u>May 19, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>May 11, 1961</u> <b>and that death occurred at</b> <u>1025 P.</u> <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>Arthur H. Lewis</u>				<b>22b. DATE SIGNED</b> <u>May 19, 1961</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>ARTHUR H. LEWIS</u>				<b>22d. ADDRESS</b> <u>1714 R I Ave NW Wash, DC</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>May 23, 1961</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>							
<b>23d. LOCATION</b> (City, town or county) (State) <u>Montgomery County, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.</u>									
<b>25a. REC'D BY REGISTRAR</b> <u>DATE MAY 26 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Christen S. Thorne</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



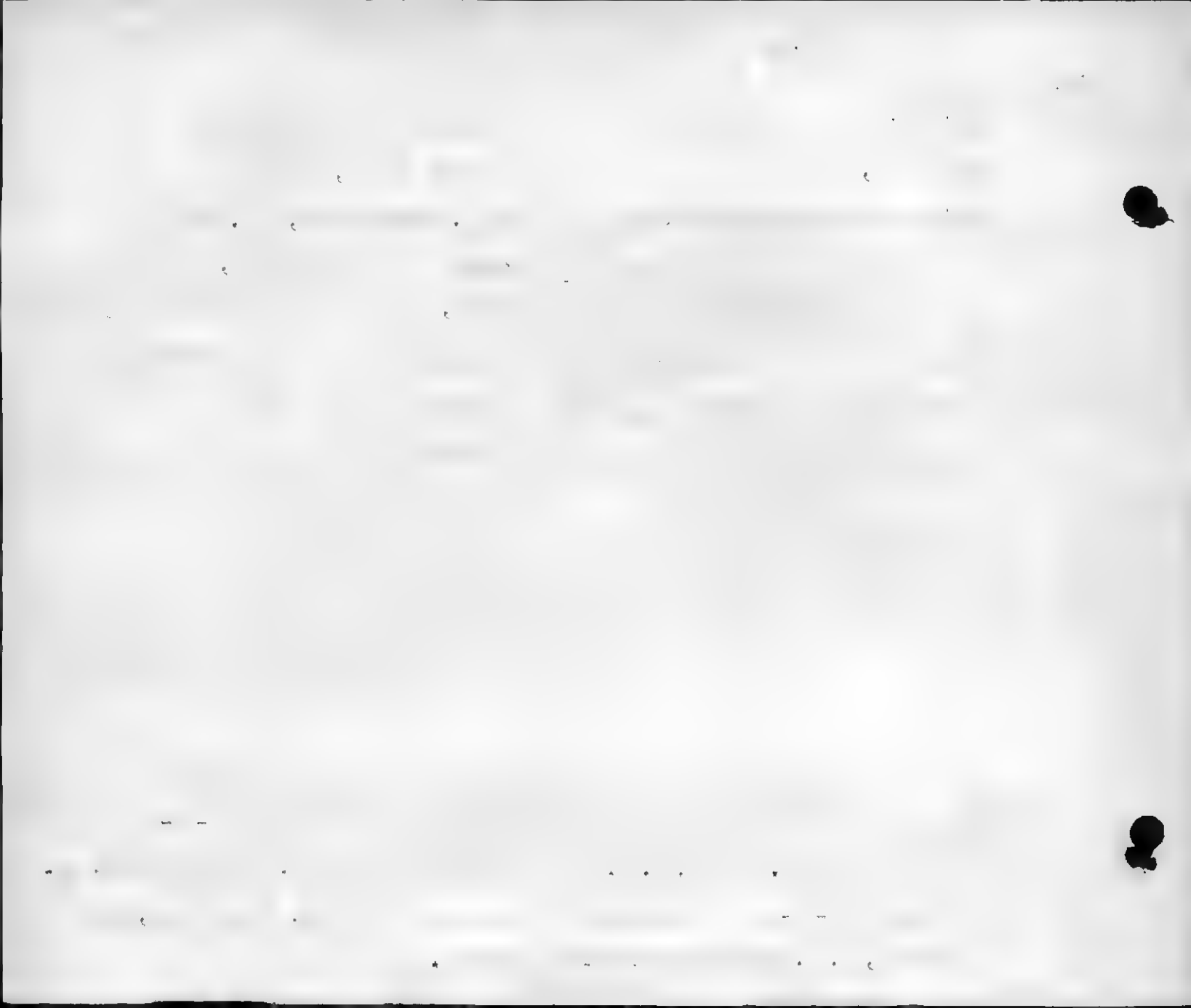
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 both be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN b1 <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>25 E. Wayne Avenue, Apt. 305</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>First Middle Last</b> <b>Male</b> <b>White</b> <b>5. SEX</b> <b>6. COLOR OR RACE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>May 18, 1961</b> <b>9. AGE</b> (In years last birthday) <b>18</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b> <b>11. BIRTH-PLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>America</b>		<b>13. FATHER'S NAME</b> <b>George Chalmers Jones</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Molina Ellen Smith</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>father</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Myocardial infarction</b> DUE TO <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>20. TIME OF INJURY</b> Hour <b>19</b> <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19</b> <b>to</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>19</b> <b>and that death occurred at</b> <b>M</b> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <b>Herbert J. Jacobs, M.D.</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>Herbert J. Jacobs, M.D.</b> <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Cremation</b> <b>23b. DATE THEREOF</b> <b>5-18-61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Washington Sanitarium and Hospital, Takoma Park, Maryland</b>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert Hare, M.D. Washington Sanitarium and Hospital</b> <b>25. REC'D BY REGISTRAR</b> <b>DATE MAY 23 '61</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hare</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

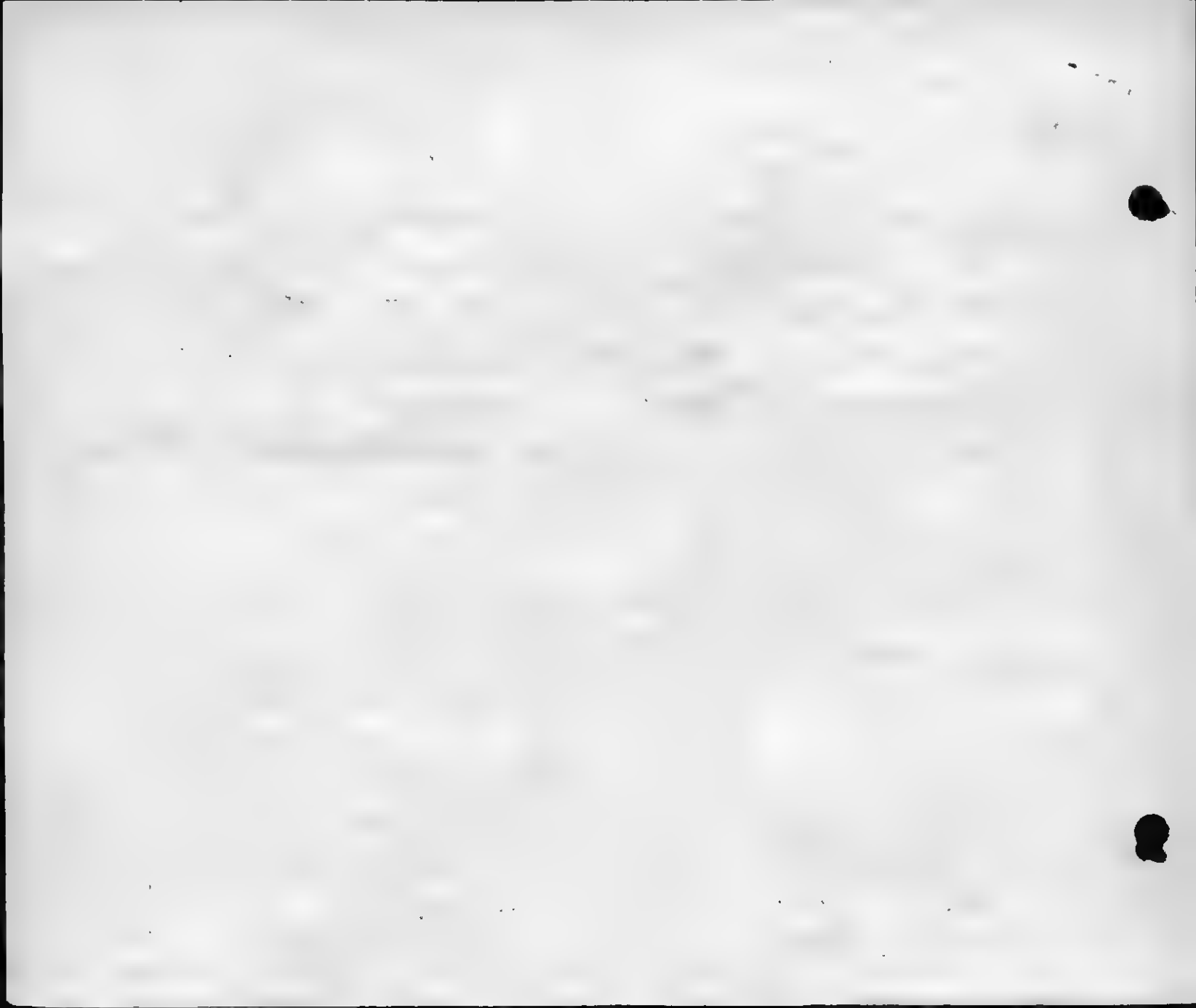
## CERTIFICATE OF DEATH

5814

05802

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>1 day 6 hrs.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>6425-78 street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Charles W. Jones</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>May 24 1961</u>			
<b>5. SEX</b> <u>Male</u>				<b>6. COLOR OR RACE</b> <u>White</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>10/4/17</u>			
<b>9. AGE</b> (In years) <u>83</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Stone Mason</u>			
<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>West Virginia U.S.A.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Samuel L. Jones</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war, dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>217-03-3635</u>			
<b>17. INFORMANT</b> <u>Mrs. Estelle Jones</u> Address <u>5200</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> (b) <u>Cerebral Thrombosis</u> (c) <u>Cerebral Atherosclerosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>5/23, 1961</u> <b>to</b> <u>5/24, 1961</u> <b>that (I) (we) last saw the deceased alive on</b> <u>5/23, 1961</u> <b>and that death occurred at</b> <u>5/24, 1961</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>AW DANISH</u>				<b>22b. DATE, SIGNED</b> <u>5/27/61</u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>AW DANISH</u>				<b>22d. ADDRESS</b> <u>927 Beeshing St. Silver Spring, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>5/27/61</u>			
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Reformed Church Cem.</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Shephardstown, W. Va.</u>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAY 29 '61</u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. L. S. Jones</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

DEPARTMENT OF HEALTH  
MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
SM 9/60

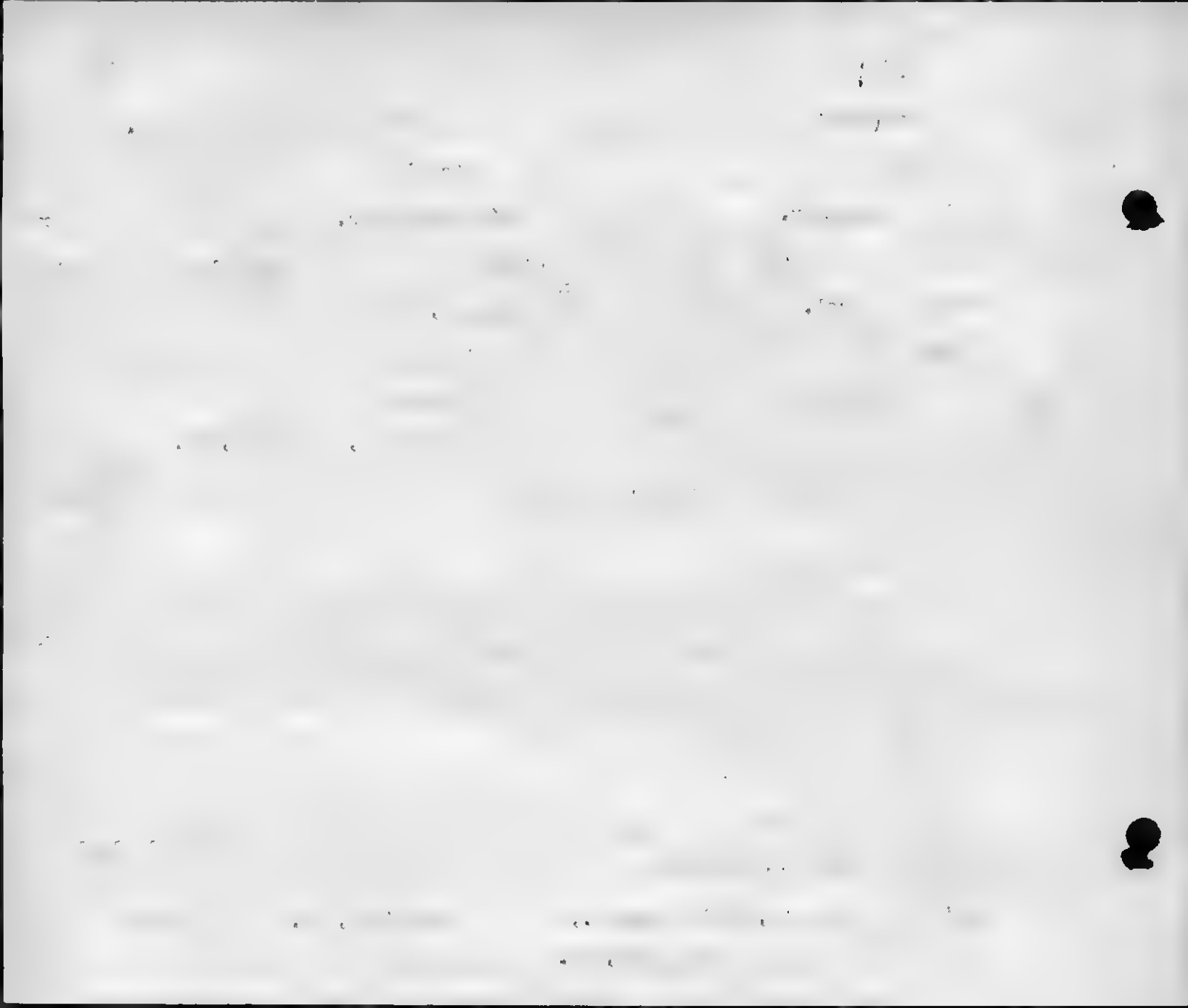
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5815

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06943

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>124 Johnson Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>124 Johnson Dr.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Jones</b>		4. DATE OF DEATH <b>May 31 19 61</b>		5. SEX <b>female</b>	
6. COLOR OR RACE <b>cel.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 20, 1883</b>	
9. AGE (In years last birthday) <b>76 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, no, or unknown)</b>		16. SOCIAL SECURITY NO. <b>(If give war or defense service)</b>		17. INFORMANT <b>Emily Harriday, Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>20.1</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County, State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 31 1961</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 27, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Latiti., Rockville, Md.</b>	
23. FUNERAL DIRECTOR <b>Robert L. Suowd</b>		24a. REC'D BY REGISTRAR <b>JUN 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Harris</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

05803

5816

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sandy Spring, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-- Mt. Airy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SALEEM SOLOMON KABALAN</b>		4. DATE OF DEATH Month Day Year <b>May 10, 1961</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1887</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor--Sewer &amp; Water</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aramoun, Lebanon</b>	
11 BIRTHPLACE (State or foreign country) <b>Naturalized</b>		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Solomon H. Kabalan</b>		14. MOTHER'S MAIDEN NAME <b>Muhsny Laytoun</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-10-9773</b>	
17. INFORMANT <b>Mr. Said S. Kabalan, Rocky River 16, Ohio</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute coronary occlusion, recurrent</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>	
420.1 DUE TO		(b) <b>Arteriosclerosis, generalized</b>	
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.		DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic congestive failure; diabetes mellitus, mild</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>4/26/61</b> , 19__ to <b>5/10/61</b> , 19__ that I last saw the deceased alive on <b>5/10/61</b> , 19__, and that death occurred at <b>8:25 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>G. F. Meadors, M.D.</b>		ADDRESS (Street, city or town, state) <b>Damascus, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>G. F. Meadors, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 15, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>North Olmsted, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAY 15 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Clifton S. Knaus</b>			

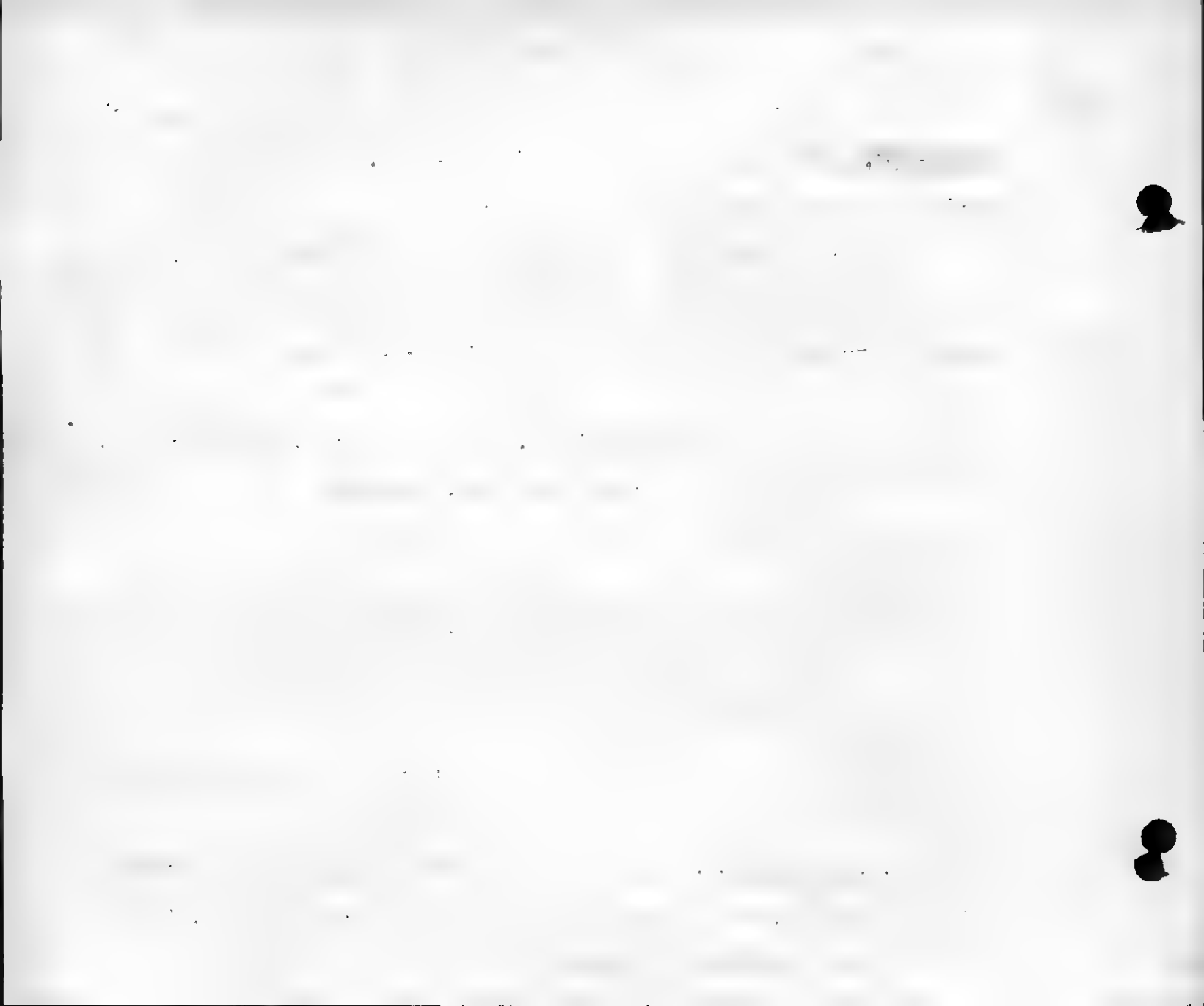
TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5817 65804

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville  
c. LENGTH OF STAY IN 1b 1/2 hr.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Lakewood Country Club

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)  
a. STATE DE  
b. COUNTY  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington  
d. STREET ADDRESS 5415 Conn. Ave., N.W.

3. NAME OF DECEASED (Type or print) Donald C. Keith  
First Middle Last  
4. DATE OF DEATH May 16 1961  
Month Day Year  
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH 12-20-05  
9. AGE (In years last birthday) 55 yrs. 10. IF UNDER 1 YEAR IF UNDER 24 HRS  
Months Days Hours Min.  
11. BIRTHPLACE (State or foreign country) Wisconsin 12. CITIZEN OF WHAT COUNTRY? U.S.A.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vitro Corp.  
10b. KIND OF BUSINESS OR INDUSTRY Vitro Corp  
11. BIRTHPLACE (State or foreign country) Wisconsin 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lincoln Keith 14. MOTHER'S M.A.DEN NAME Cora Cain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Alice Keith-sister-3338016th Street, N.W.  
Address Washington, D.C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary occlusion  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 2201 DUE TO  
(c) Interval between onset and death  
Dead suddenly while playing golf.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS ALTOSY PERFORMED?  
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

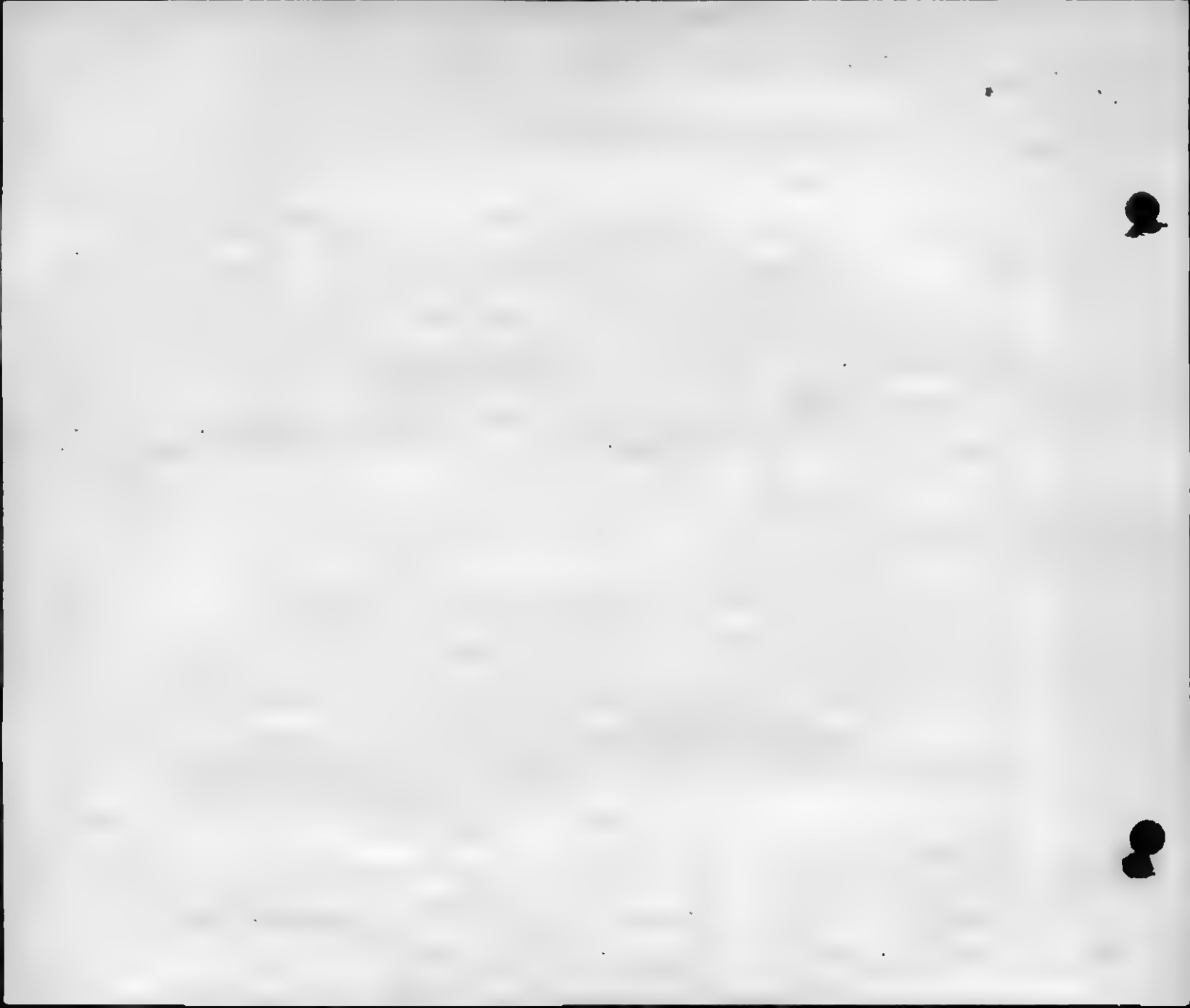
21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschait M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) FRANK J. Broschait ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED 5-16-61  
DEPUTY MEDICAL EXAMINER ☒ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 5/17/61 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory 22d. LOCATION (City, town, or county) (State) Suitland, Maryland

23. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR MAY 19 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Harris





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5815											
05805											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>							
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN b <b>31 years</b>				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				d. STREET ADDRESS <b>4211 Bradley Lane</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. NAME OF DECEASED (Type or print) <b>William Henry Kelley</b>				g. DATE OF DEATH <b>May 29 1961</b>				h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>11/12/74</b>				9. AGE (If years, last birthday) <b>86</b>				10. IF UNDER 1 YEAR: Months <b>29</b> Days <b>19</b> Hours <b>61</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Custodian</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Am. Security Bank</b>				11. BIRTHPLACE (County & State, or foreign country) <b>S. Coventry, Conn.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>				13. FATHER'S NAME <b>Patrick Kelley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Branigan</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>579-01-5209A</b>				17. INFORMANT <b>Mrs. Esther Cantrell (Daughter)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> DUE TO X CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Perforated Duodenal Ulcer</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>September 1955</b> to <b>May 29, 1961</b> , that (I) <b>(two)</b> last saw the deceased alive on <b>May 28, 1961</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>J. Blaine Fitzgerald</b>				22b. PHYSICIAN'S NAME (Type) <b>J. Blaine Fitzgerald</b>				22c. ADDRESS <b>8218 Unionville Avenue Bethesda</b>			
22d. DATE SIGNED <b>5-29-61</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. ADDRESS <b>8218 Unionville Avenue Bethesda</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>6/7/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Mount St. Benedict Cemetery</b>			
23d. LOCATION (City, town or county) <b>Hartford, Conn.</b>				23e. (State)				23f. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc.</b>				24a. ADDRESS <b>8434 Georgia Ave. SS Md.</b>				24b. REC'D BY REGISTRAR <b>Raymond A. Ziska</b>			
24c. DATE <b>JUN 6 '61</b>				24d. REGISTRAR'S SIGNATURE <b>Carlton S. Hanna</b>				24e. (State)			



FOR STATE  
HEALTH DEPT.

(M)

(I)

THIS DEATH CERTIFICATE should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>5819</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05806</div> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3304 Winnett Rd</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u> d. STREET ADDRESS <u>3304 Winnett Rd</u>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Rodham Woinder Kenner</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-19-1908</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. MONTH <u>May</u> 11. DAY <u>30</u> 12. YEAR <u>1961</u>						<b>9. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Executive</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Little Tavern</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>						<b>13. FATHER'S NAME</b> <u>Harry W. Kenner</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Ada Crandall</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Betty Kenner (wife) Item 2</u>						<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>101</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>					
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>History of previous heart disease</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> M.D. <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>5-30-61</u> <b>Address (Street, city, town, or county)</b>											
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>22b. DATE THEREOF</b> <u>6/1/61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u> <b>22d. LOCATION (City, town, or country)</b> <u>Suitland, Maryland</u> <b>23. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey</u> <b>ADDRESS</b> <u>Bethesda, Maryland</u> <b>24a. REC'D BY REGISTRAR</b> <u>June 2 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kline</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

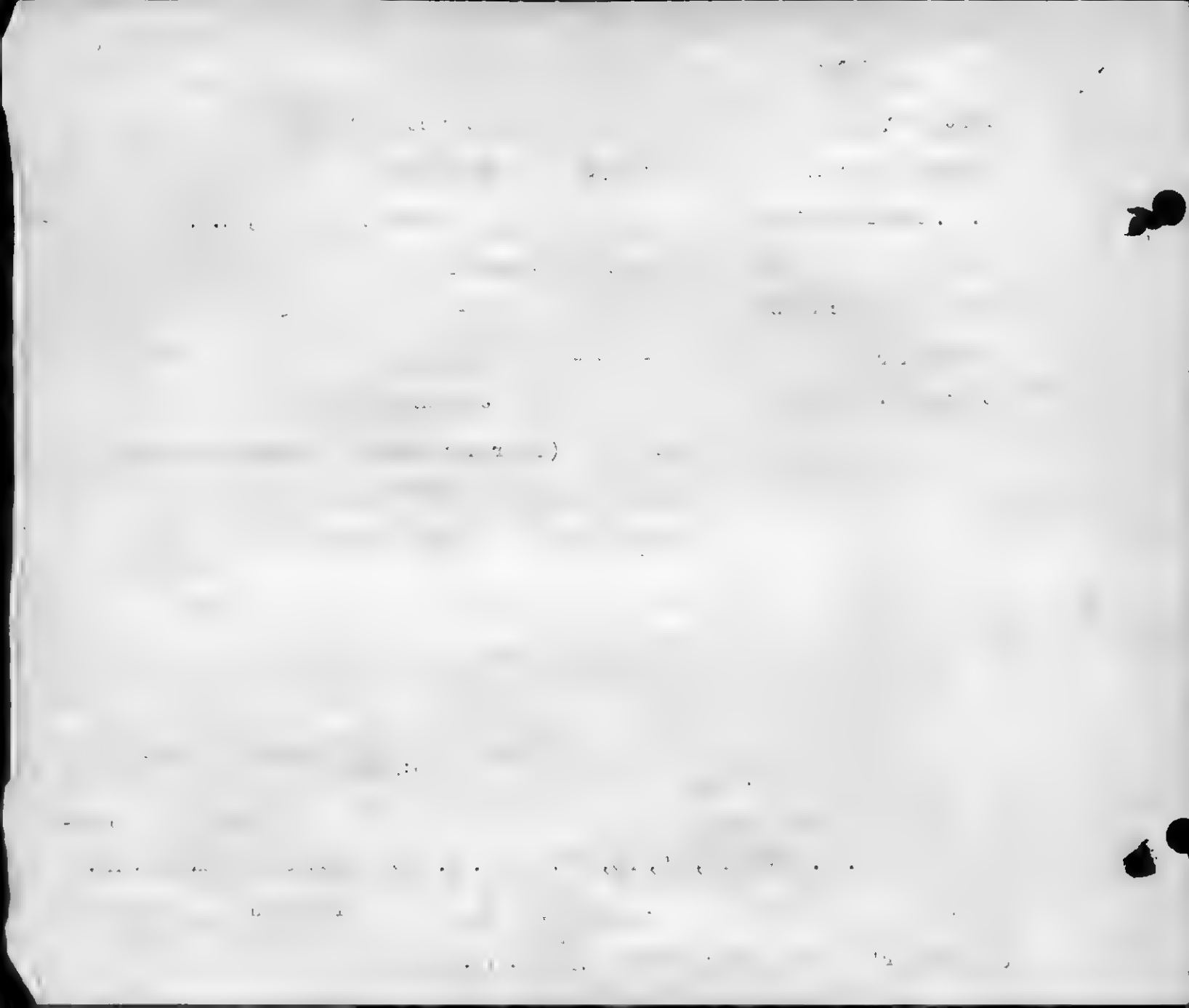
Form 20 Film 288  
5-11-61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5820

65802

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3100 Connecticut Ave., N.W.</b> d. STREET ADDRESS <b>3100 Connecticut Ave., N.W.</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Adele Cooke KINGSTON</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>May 19 19 61</b>	
<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>9-25-79</b>		<b>9. AGE</b> (in years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months Days Hours Mins. <b>81</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-----</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Charles W. COOKE</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine ROGERS</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>(H) Arthur Kingston, same as #2 above</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary Embolism</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>postoperative open reduction left femur fracture</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell at home</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>6</b> Hour <b>3:00</b> p.m. <b>5-11</b> 19 <b>61</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work <b>Home</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
<b>20f. (City or town)</b> <b>Washington</b>		<b>20g. (County)</b> <b>D.C.</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (th's hospital) attended the deceased from <b>May 13</b> 19 <b>61</b> , to <b>May 19</b> 19 <b>61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 19</b> 19 <b>61</b> , and that death occurred at <b>4:55AM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>G. B. Townsend</b>		<b>22b. DATE SIGNED</b> <b>5-19-61</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>G. B. TOWNSEND, LT, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>5/23/1961</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION (City, town or county)</b> <b>Arlington</b>	
<b>23e. ADDRESS</b> <b>WashDC</b>		<b>23f. REGISTRAR'S SIGNATURE</b> <b>Charles S. House</b>	
<b>23g. REGISTRAR'S NAME</b> <b>John Gawler's &amp; Sons Funeral Home, 1756 Pa. Ave. NW</b>		<b>23h. DATE</b> <b>MAY 24 '61</b>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

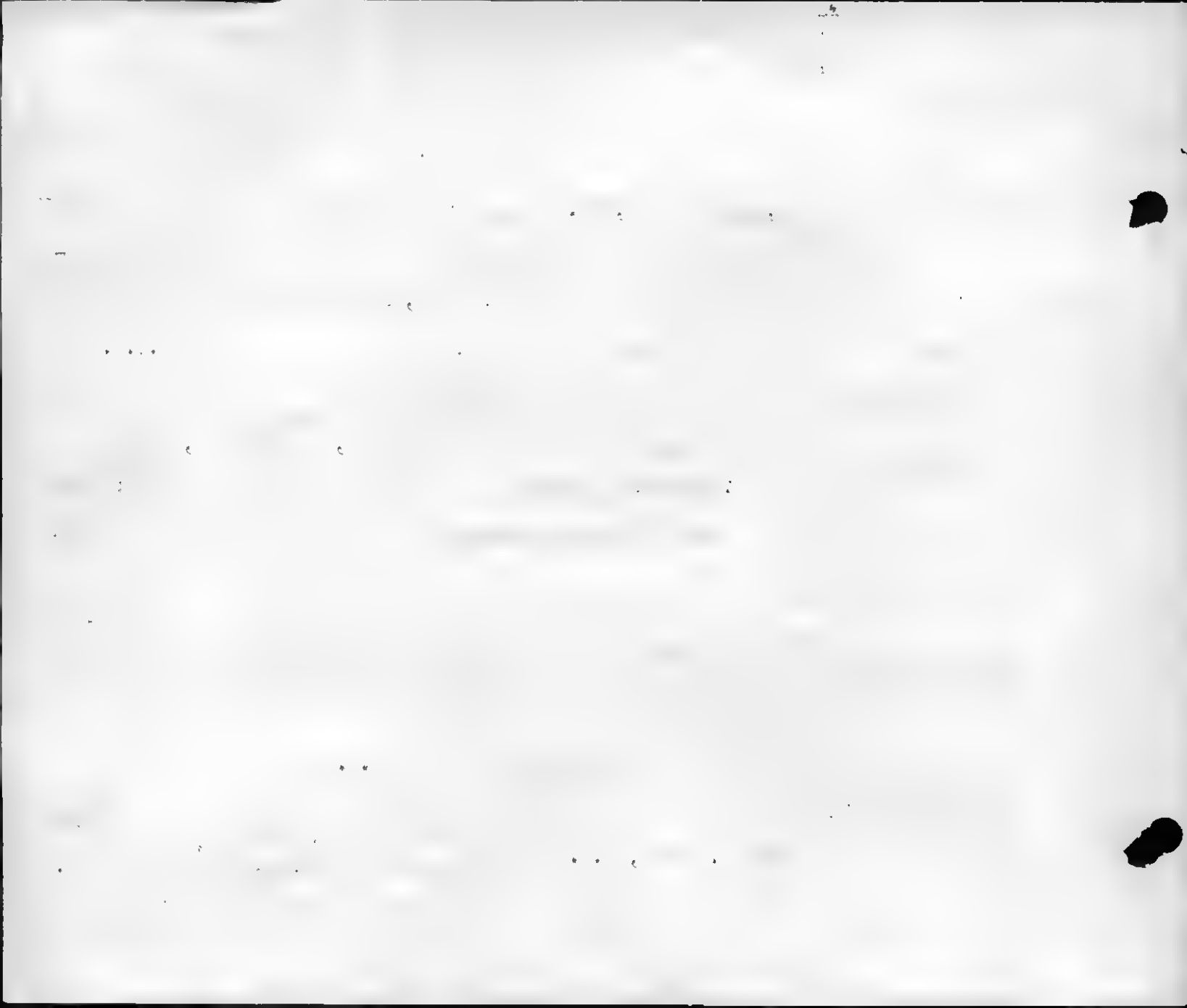
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5821

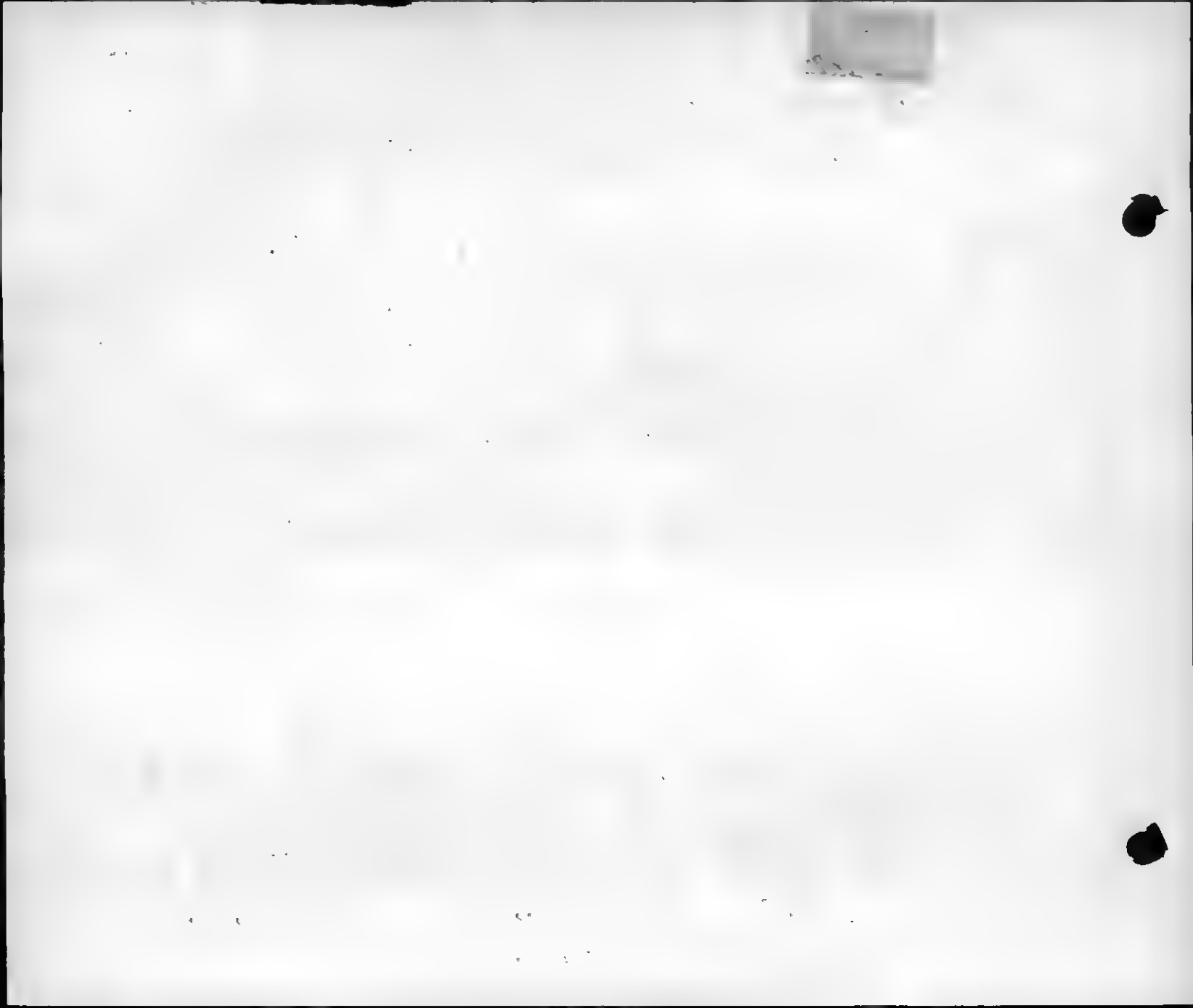
65898

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>238 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>11908 Coronada Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Trudy</b> Middle <b>Lynn</b> Last <b>Kruis</b>				4. DATE OF DEATH Month <b>May</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 21, 1951</b>	
9. AGE (In years last birthday) <b>9</b> yrs		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Kruis</b>				14. MOTHER'S MAIDEN NAME <b>Mae Van Zwol</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>? Pulmonary embolus</b> 1.3 DUE TO <b>Acute lymphocytic leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Acute lymphocytic leukemia</b> (c) <b>Acute lymphocytic leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute lymphocytic leukemia</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>8 months</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 21, 1960</b> to <b>May 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 17, 1961</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Jerome B. Block</b>		M.D. <b>Jerome B. Block, M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>5/18/61</b>	
22c. PHY. NAME <b>Jerome B. Block</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
23a. BURIAL, REMOVAL, or other disposition <b>Burial</b>		23b. DATE THEREOF <b>May 12, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hudsonville, Mich.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Chambers &amp; Co. Rindell Inc.</b>				25. REC'D BY REGISTRAR <b>DATA 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruis</b>	









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

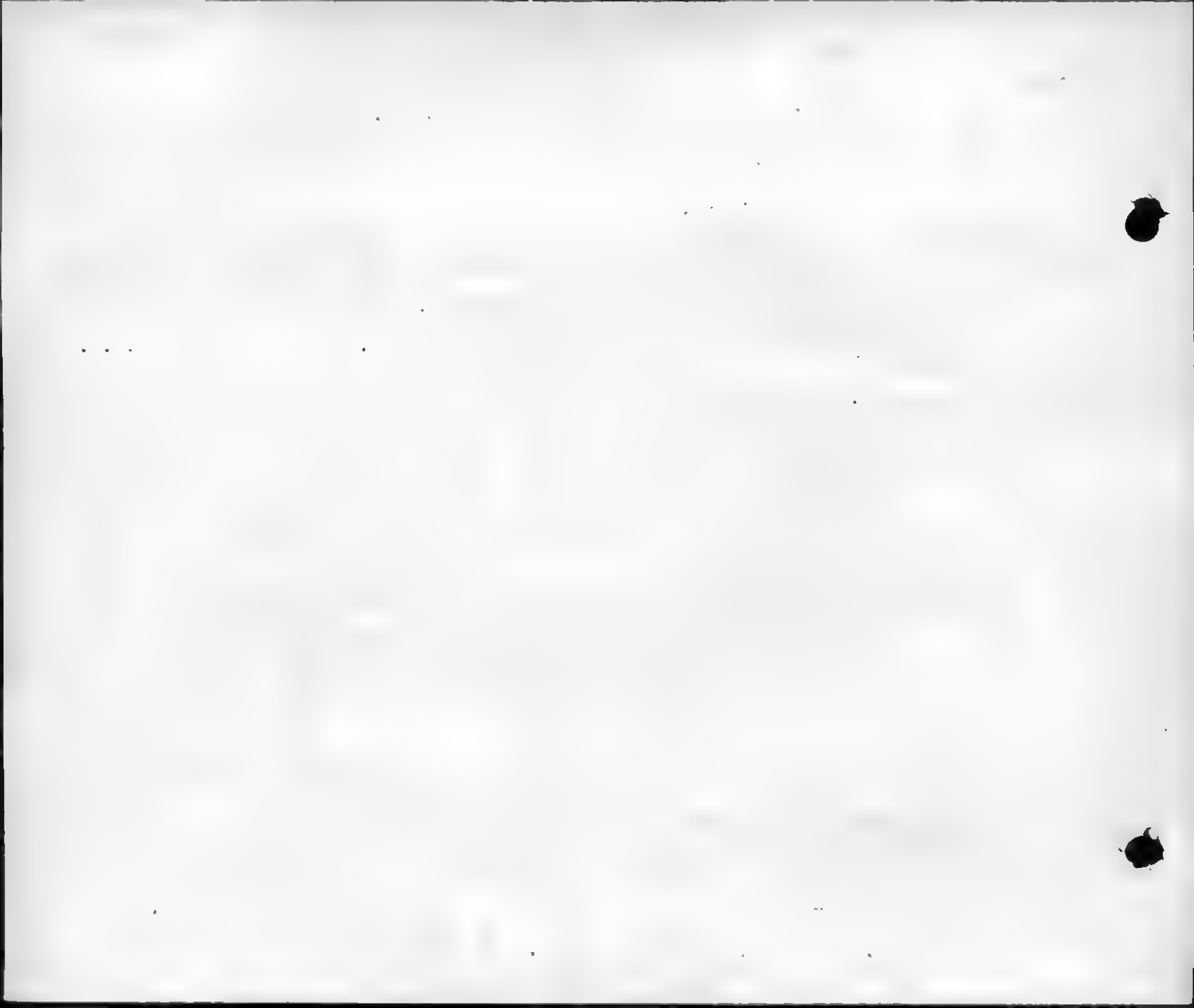
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5829

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05810

1. PLACE OF DEATH a. COUNTY <b>Montg.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>/</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg Montg.</b>				c. LENGTH OF STAY IN 1b <b>21 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>				d. STREET ADDRESS <b>825</b>			
3. NAME OF DECEASED (Type or print) First <b>Delilah</b> Middle <b>May</b> Last <b>Legg</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1870</b>	9. AGE (In years, last birthday) <b>90 yrs</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>6</b>	F UNDER 24 HRS. Hours <b>/</b> Min <b>/</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hampshire Co., West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel W. Anderson</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Kibler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>/</b>		16. SOCIAL SECURITY NO. <b>/</b>		17. INFORMANT Address <b>Asbury Methodist Home Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>411</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>/</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>/</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-20</b> , 19 <b>60</b> , to <b>5-11</b> , 19 <b>61</b> , that (I) ( <b>/</b> ) last saw the deceased alive on <b>5-11</b> , 19 <b>61</b> , and that death occurred at <b>7:00 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>James W. Egan</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>5-11-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James W. Egan</b>				22d. ADDRESS <b>7720 Wisconsin Ave Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-13-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Timber Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>(Near) Gore. W. Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>				ADDRESS <b>Gaithersburg, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5824

Item 2-Film G287 5/22/61

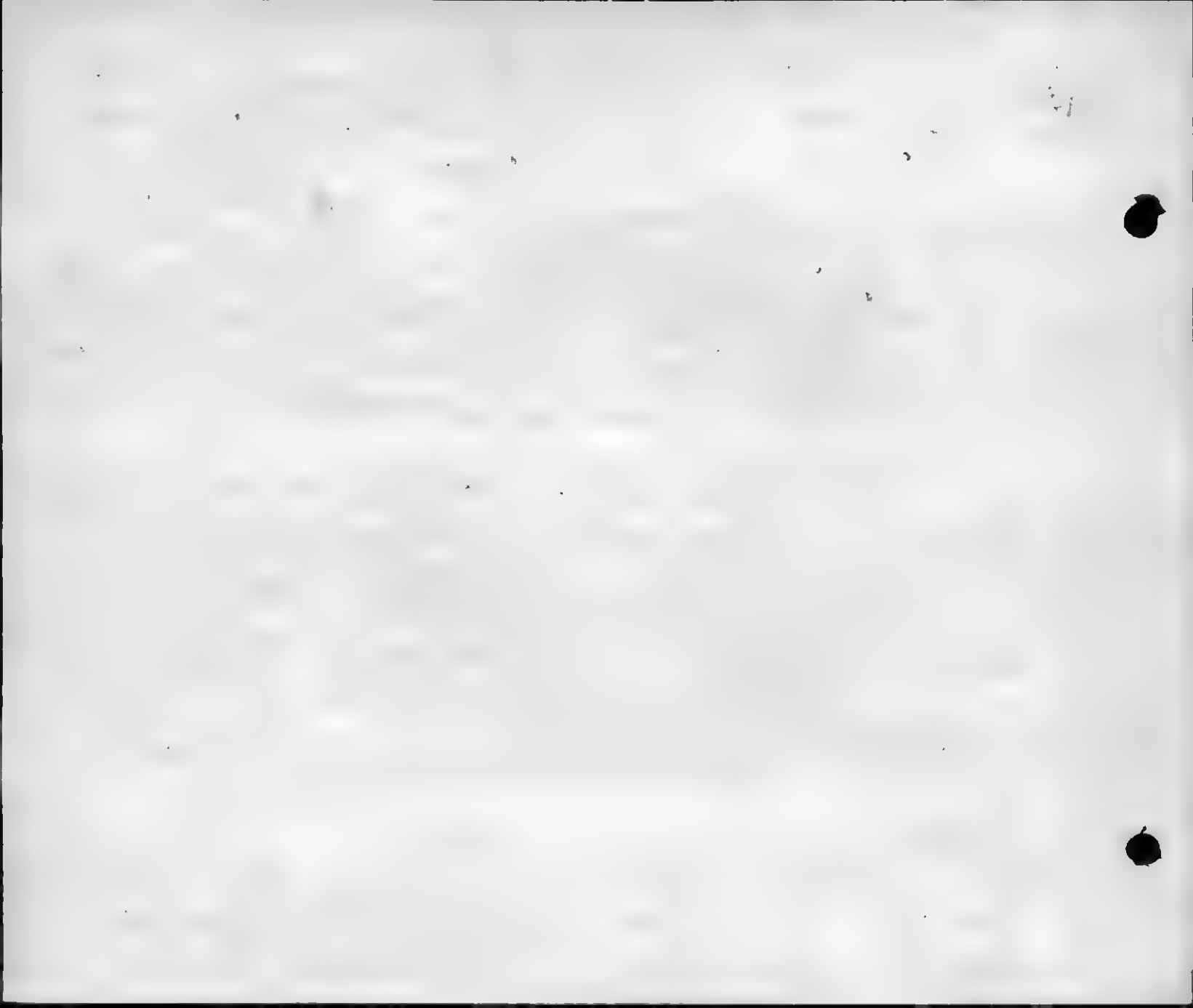
05811

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. LENGTH OF STAY IN 1b <b>—</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKLYN KENSINGTON</b>		d. STREET ADDRESS <b>1123 BROADWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IDA</b>		First <b>IDA</b>		Middle <b>MARIAN</b>		Last <b>LLOYD</b>		4. DATE OF DEATH <b>MAY 10 1961</b>		Month <b>MAY</b>		Day <b>10</b>		Year <b>1961</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 27 1870</b>		9. AGE (In years last birthday) <b>90</b> yrs.		If UNDER 1 YEAR: Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (County & State or foreign country) <b>ENGLAND</b>	
13. FATHER'S NAME <b>WILLIAM LINNELL</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA GELL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO <b>—</b>		17. INFORMANT <b>—</b>		Address <b>—</b>		12. CITIZEN OF WHAT COUNTRY? <b>GREAT BRITAIN</b>		Interval between ONSET and DEATH <b>14 DAYS</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SENILITY</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>—</b> p.m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JULY 21, 1957</b> to <b>MAY 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 10, 1961</b> , and that death occurred at <b>P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry M. Lowden</b>		22b. DATE SIGNED <b>5-10-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>		22d. ADDRESS <b>3206 NOMAN PT. CHERRY CREEK RD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>5-12-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gwiler's Sons, Inc.</b>		25. REC'D BY REGISTRAR <b>MAY 12 '61</b>	
ADDRESS <b>1756 - Pa. Ave. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5825

05812

1. PLACE OF DEATH  
a. COUNTY MONTGOMERY  
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) JRtHOMAS PRk  
c. LENGTH OF STAY IN 1b 3 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SENIORITY HOME

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND  
b. COUNTY MONTGOMERY  
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) SILVER SPRING  
d. STREET ADDRESS 8710 DUMMELH

3. NAME OF DECEASED (Type or print) Robert Glenn Lloyd  
First Middle Last  
4. DATE OF DEATH May 7, 1961  
Month Day Year  
5. SEX M  
6. COLOR OR RACE White  
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 6-11-15  
9. AGE (In years last birthday) 45 yrs.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Highway Insp., D.C. Govt  
10b. KIND OF BUSINESS OR INDUSTRY Police  
11. BIRTHPLACE (County & State, or foreign country) Penn.  
12. CITIZEN OF WHAT COUNTRY U.S.A.  
13. FATHER'S NAME John Lloyd  
14. MOTHER'S MAIDEN NAME Ruth Fotters

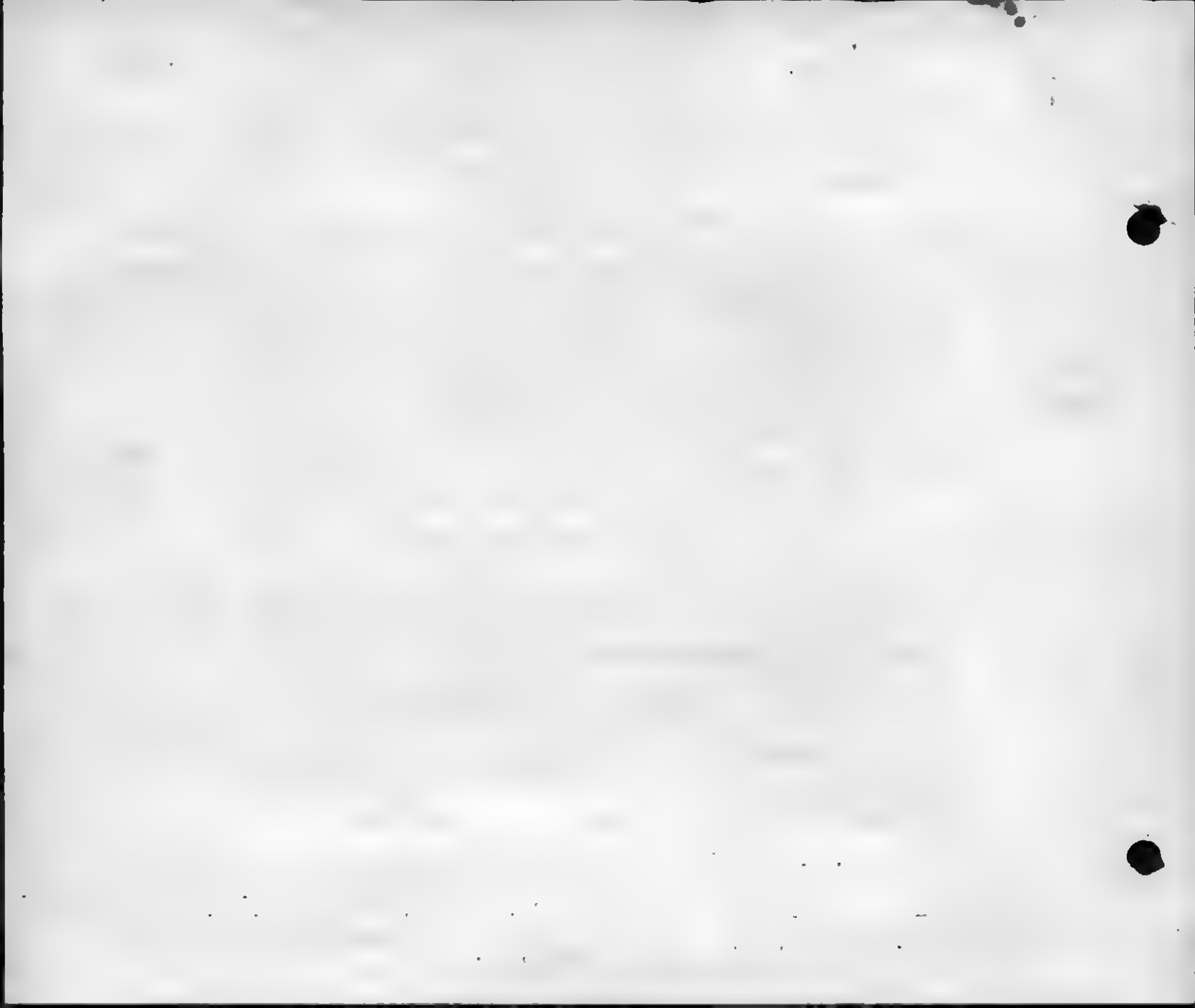
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW2 Army  
16. SOCIAL SECURITY NO. 303-11-127-15  
17. INFORMANT Kathryn Lloyd - as deceased  
Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Inanition  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Abdominal Acites  
(c) Cirrhosis of Liver  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from June 1960 to 5-6-1961, that (I) (we) last saw the deceased alive on 5-6-1961, and that death occurred at 5:25 A.M. from the causes and on the date stated above.  
22a. SIGNATURE N. C. Shoemaker M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ DATE SIGNED 5/7/61  
22b. PHYSICIAN'S NAME (Type) N. C. Shoemaker  
22c. ADDRESS 8005 Woodbury & Silver Spring, Md  
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial  
23b. DATE THEREOF 5/7-5/10/61  
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cemetery, Arlington Co., Va. via McKee Spout  
23d. LOCATION (City, town or county) (State) Silver Spring, Md.  
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska ADDRESS SILVER SPRING, MD.  
25a. RECD BY REGISTRAR MAY 12 '61 DATE  
25b. REGISTRAR'S SIGNATURE Arthur S. Evans

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.





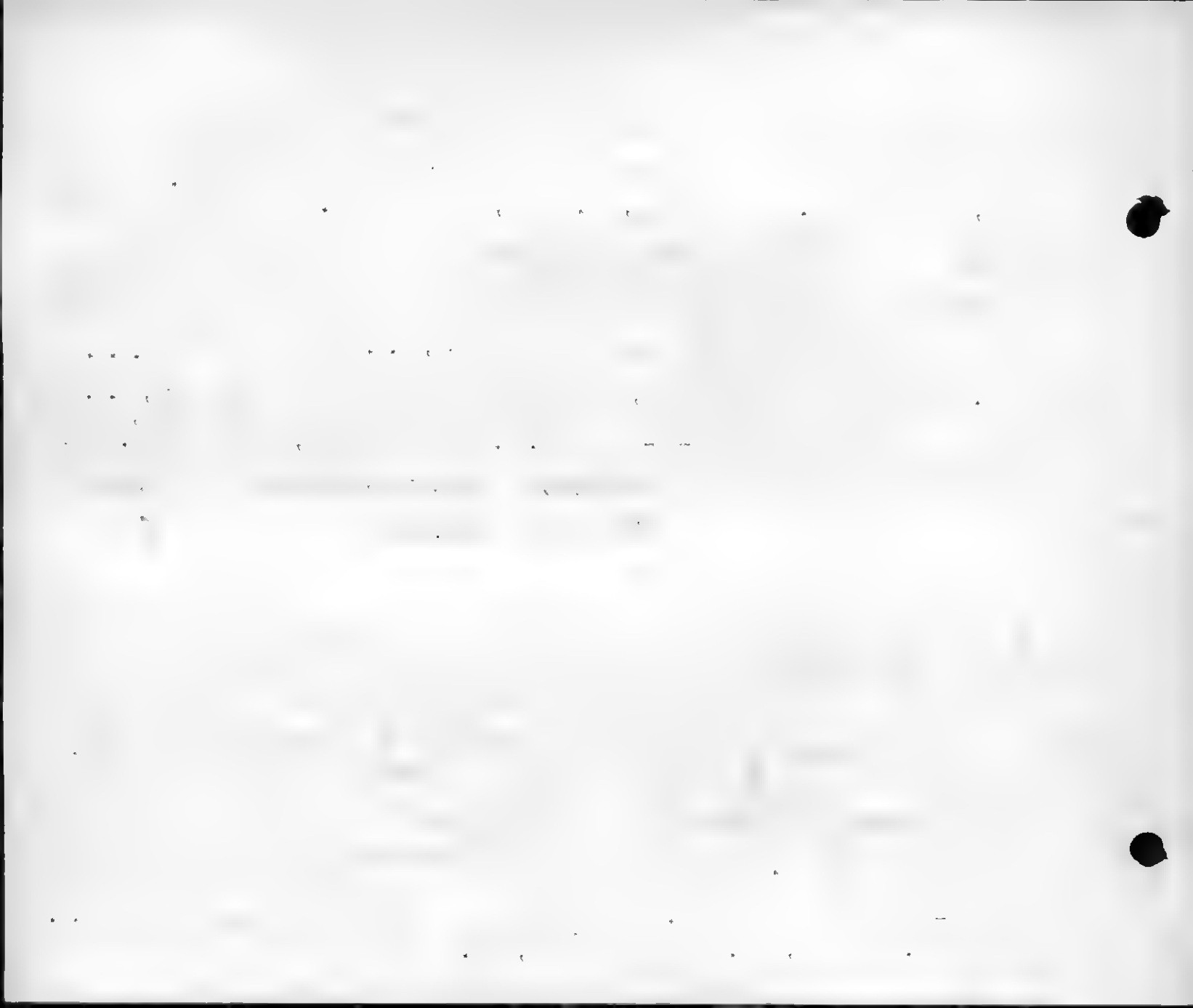
may be required by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5826

05813

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>Nine years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,033 Renfrew Rd. Silver Spring, Md.</b>		d. STREET ADDRESS <b>10,033 Renfrew Rd. Silver Spring Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>HELEN</b> Last <b>MANZI</b>		4. DATE OF DEATH Month <b>5</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/20/14</b>
9. AGE (In years last birthday) <b>46</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Mohawk, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mr. John Bell</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Keough</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>081-03-6973</b>	
17. INFORMANT <b>Mr. A. Robert Manzi</b>		Address <b>Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEPATIC INSUFFICIENCY</b> DUE TO <b>HEPATIC CIRRHOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 wks</b> <b>6 mos.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 1961</b> to <b>MAY 1961</b> , that (I) (we) last saw the deceased alive on <b>5-15-1961</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Bernard A. Fitzgerald</b>		22d. ADDRESS <b>217 UNIVERSITY BLVD E. S.S. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 5/21/61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Agnes Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Onondaga County Syracuse N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc. 8434 Georgia Ave., Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 23 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOPE: The law requires that the death certificate be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park Md.  
c. LENGTH OF STAY IN (b) 55 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if not within residence before admission)  
a. STATE Md. b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington  
d. STREET ADDRESS 9628 Old Spring Rd

3. NAME OF DECEASED (Type or print) Elizabeth Cole Marsteller  
First Middle Last  
4. DATE OF DEATH May 24 1961  
Month Day Year

5. SEX F 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 1-29-02  
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M. n.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY D.C. 11. BIRTHPLACE (County & State, or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George R. Cole 14. MOTHER'S MAIDEN NAME Minnie Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT chart - Wash. San. Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Carcinoma of Breast & Metastases  
170X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) 170X  
cause last, stating the underlying cause last. (c) DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Pleural Empyema

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

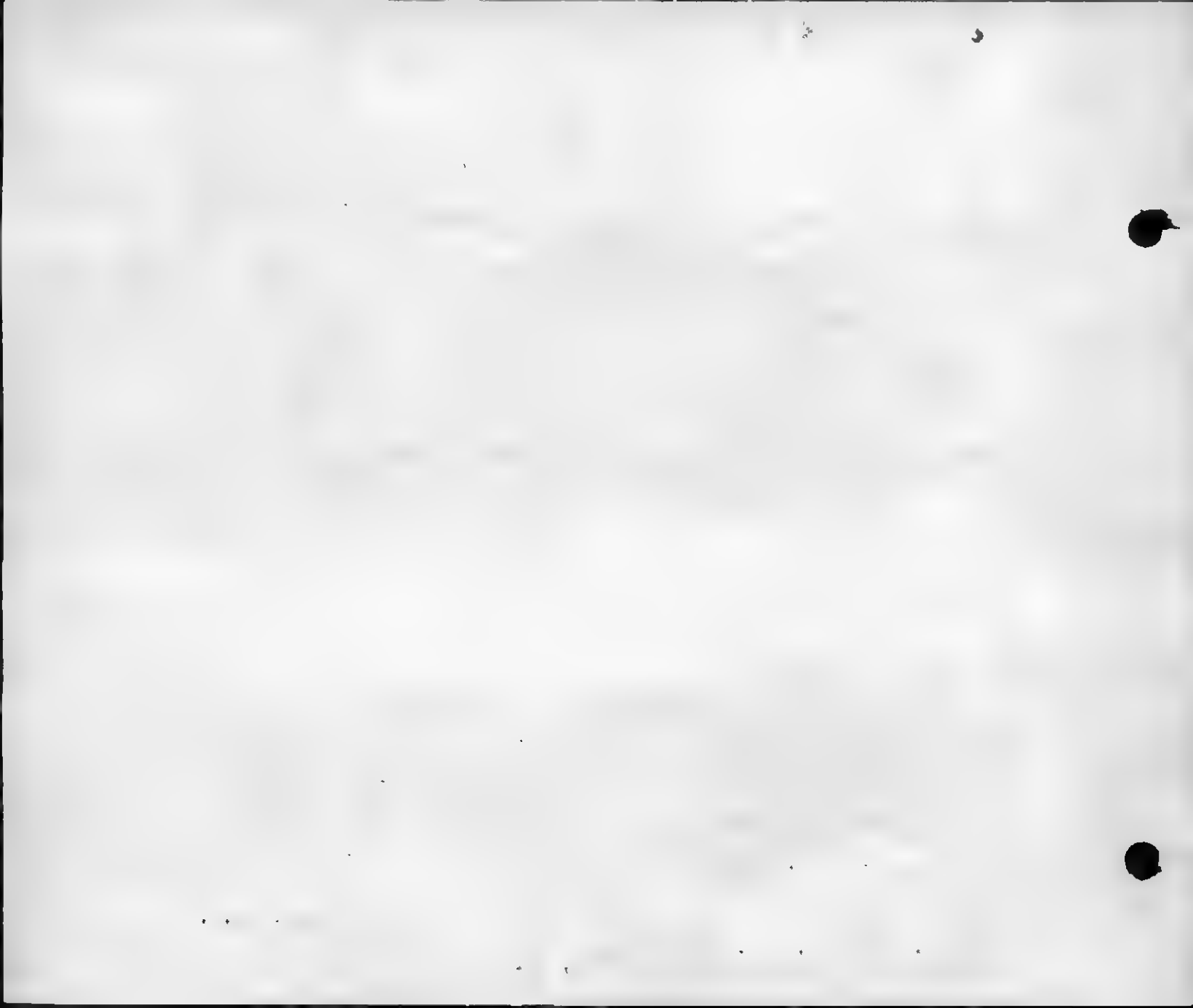
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-7 1961, to 5-24 1961, that (I) (we) last saw the deceased alive on 5-24 1961, and that death occurred at 10:45 AM, from the causes and on the date stated above.

22a. SIGNATURE James W. Egan 22b. DATE SIGNED 5/24/61  
22c. PHYSICIAN'S NAME (Type) James W. Egan 22d. ADDRESS 7720 Wisconsin Ave. - Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/27/61 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery 23d. LOCATION (City, town or county) (State) Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md. 25a. RECD BY REGISTRAR DATE MAY 31 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



5828

CERTIFICATE OF DEATH

Reg. Dist. No.

05815

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clevey Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clevey Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3201 Pickwick Lane</u>		d. STREET ADDRESS <u>3201 Pickwick Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Eugene J.</u> Middle <u>Matchett</u> Last		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/11/09</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>12</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administrative officer Dept. of Justice</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas L. Matchett</u>		14. MOTHER'S MAIDEN NAME <u>Harriet M. Ramler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Eugene J. Matchett, Jr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma (metastatic) Lung</u> DUE TO 165X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1959</u> to <u>May 3, 1961</u> that I last saw the deceased alive on <u>May 3, 1961</u> and that death occurred at <u>5:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur H. Lewis</u> M.D.		ADDRESS (Street, city or town, state) <u>1714 R I Ave NW</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR H. LEWIS</u>		DATE SIGNED <u>5/3/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>5/6/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.F. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>DATE MAY 8 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









TO HOSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

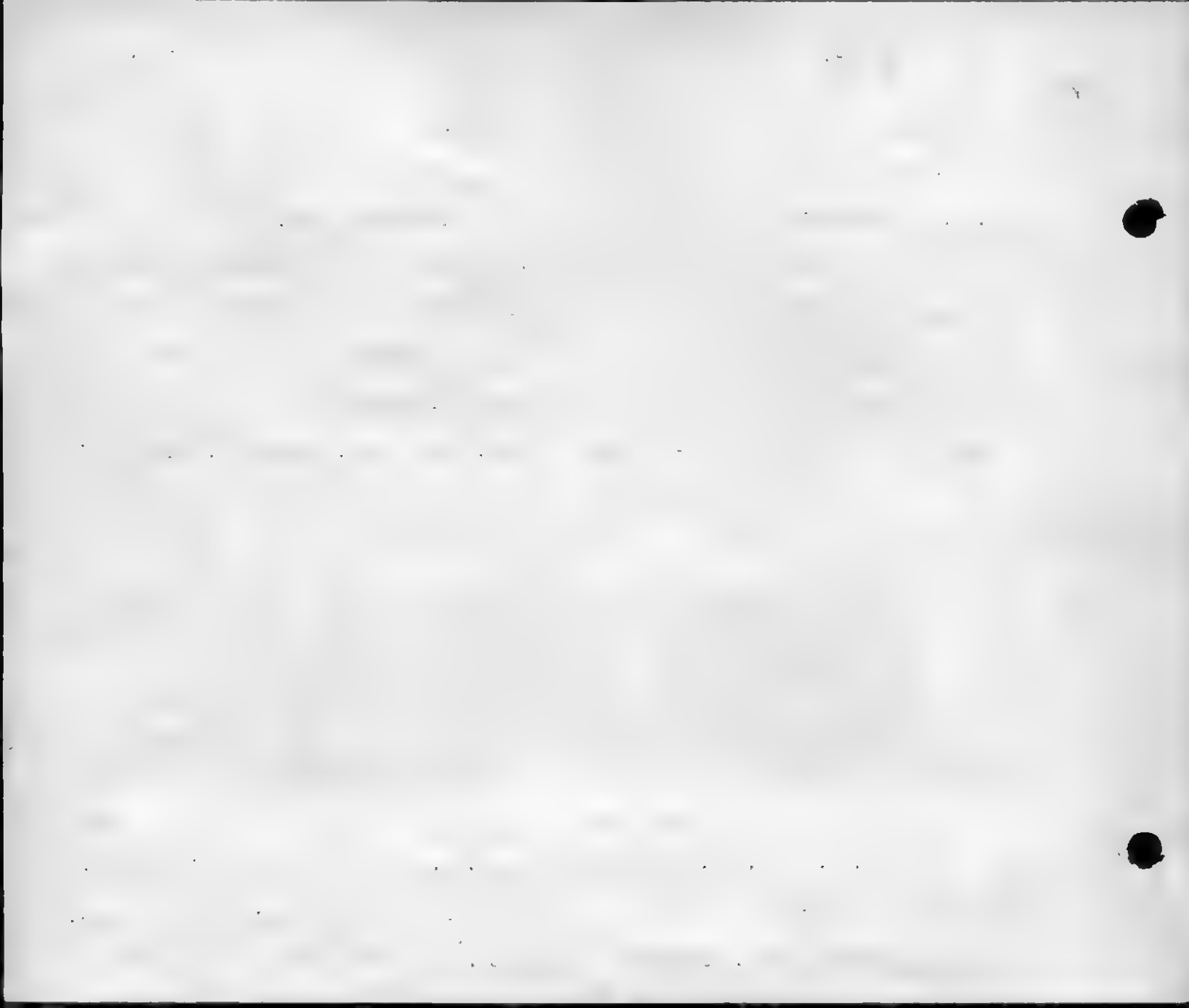
## CERTIFICATE OF DEATH

5830

65817

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>83</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>35 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
3. NAME OF DECEASED (Type or print) <b>Allen</b>		f. STREET ADDRESS <b>408 E. Glendale Ave.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-20-34</b>	
9. AGE (in years last birthday) <b>26 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>61</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronic Technician</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ross W. MC DERMOTT</b>		14. MOTHER'S MAIDEN NAME <b>Mamie E. KROMLING</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>230-42-0365</b>	
17. INFORMANT <b>(W) Mrs. Patricia A. McDermott, same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>201X</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>INTERVAL BETWEEN ONSET AND DEATH 4 yrs.</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>March 27, 1961</b> to <b>May 1, 1961</b> that (X) (we) last saw the deceased alive on <b>May 1, 1961</b> and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. G. Muth</b>		22b. DATE SIGNED <b>5-1-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. G. MUTH, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Cunningham Funeral Home, Cameron &amp; Alfred Sts.</b>		25a. REC'D BY REG. STRAR <b>DATE MAY 3 '61</b>	

VR A15 (4)  
15M 9/60



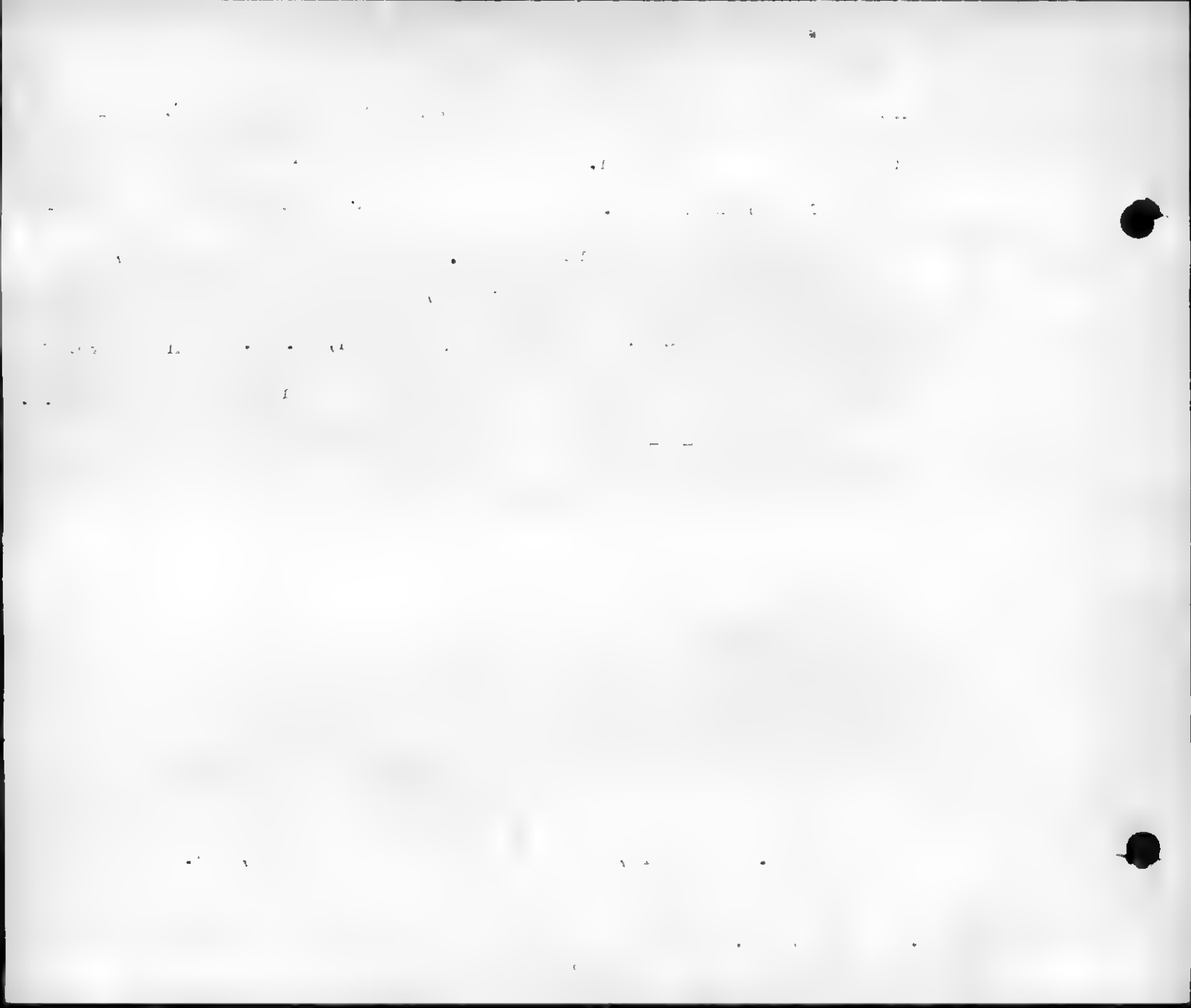
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5831

05818

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>25 min.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery General Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>Paul</b> Last <b>McKay</b>				4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 9, 1891</b>	
9. AGE (In years last birthday) <b>70</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurseryman</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>William McKay</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Lang</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW #1</b>				16. SOCIAL SECURITY NO. <b>214-03-9362</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1954</b> to <b>May 20, 1961</b> that (I) (we) last saw the deceased alive on <b>May 20, 1961</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Alfred D. Bonifant</b>				22b. DATE SIGNED <b>5/20/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Alfred D. Bonifant, MD</b>				22d. ADDRESS <b>Silver Spring, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/24/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Montgomery County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>				25a. REC'D BY REGISTRAR <b>MAY 26 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	
24. ADDRESS <b>8434 Georgia Avenue Silver Spring, Maryland</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. If 3 or 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

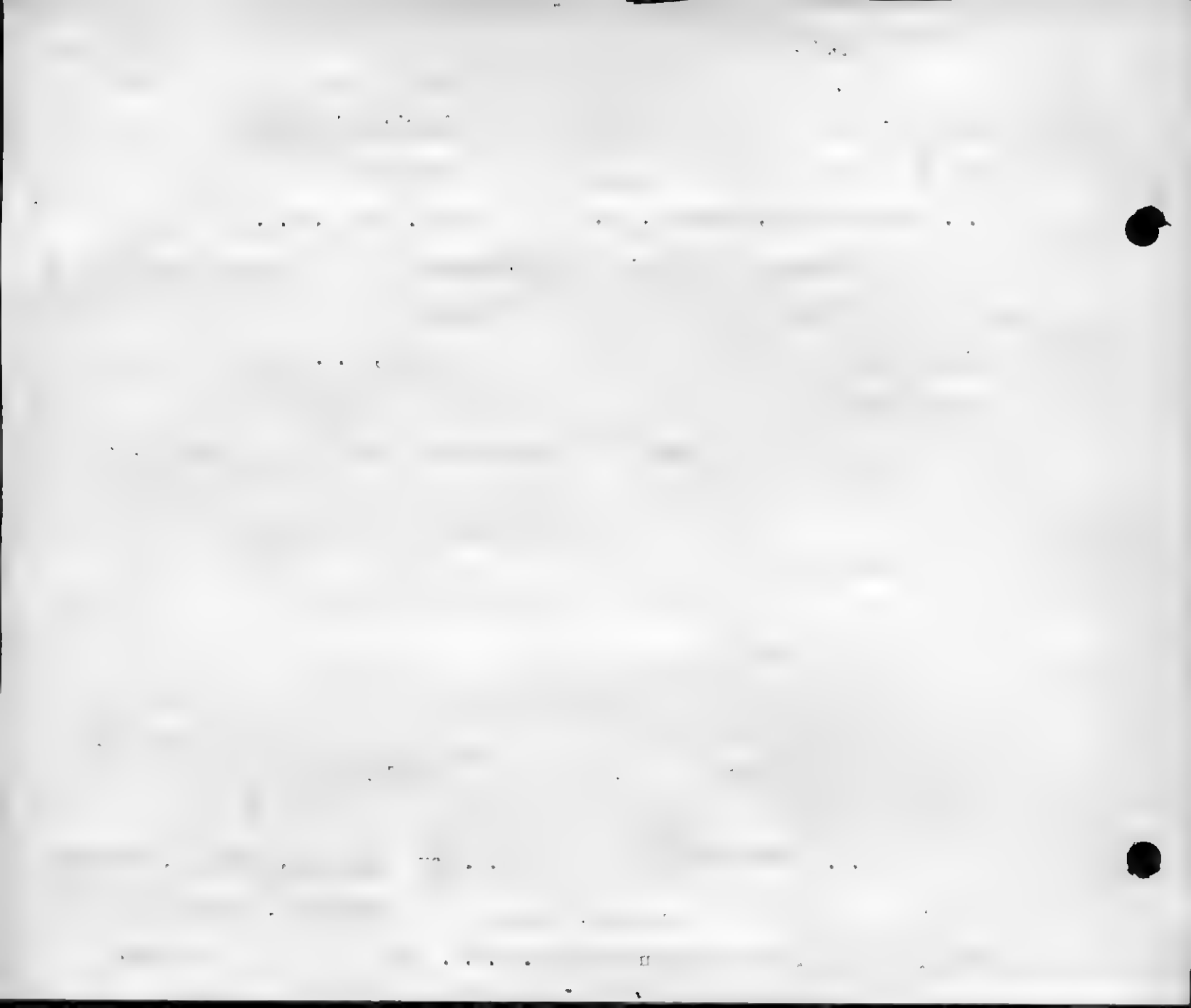
VR A15 (4)  
15M 9/60

5832

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05814

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>814 E. Street, N.E.</b> d. STREET ADDRESS <b>47X-</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elnora Marie MC LAUGHLIN</b>		4. DATE OF DEATH <b>May 12 19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>18 June 1883</b>	
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10. BIRTHPLACE (County & State or foreign country) <b>Washington, D.C.</b>	
11. FATHER'S NAME <b>James Asbury</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		14. SOCIAL SECURITY NO. <b>None</b>	
15. INFORMANT <b>James Edward MC LAUGHLIN</b>		16. ADDRESS <b>Same as #2 above</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (c) DUE TO cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>5 years</b>	
19. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 23. (City or town, County, State)	
24. I certify that (this hospital) attended the deceased from <b>8 May</b> 19 <b>61</b> to <b>12 May</b> 19 <b>61</b> that (we) last saw the deceased alive on <b>12 May</b> 19 <b>61</b> , and that death occurred at <b>11 AM</b> from the causes and on the date stated above.			
25a. SIGNATURE <b>J.M. Young</b>		25b. DATE <b>17 May 1961</b>	
26. PHYSICIAN'S NAME (Type) <b>J.M. YOUNG LT MC USN</b>		27. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>	
28. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29. DATE THEREOF <b>5-16-61</b>	
30. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		31. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
32. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		33. ADDRESS <b>4th &amp; Massachusetts Ave. W.D.C.</b>	



may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5833

05820

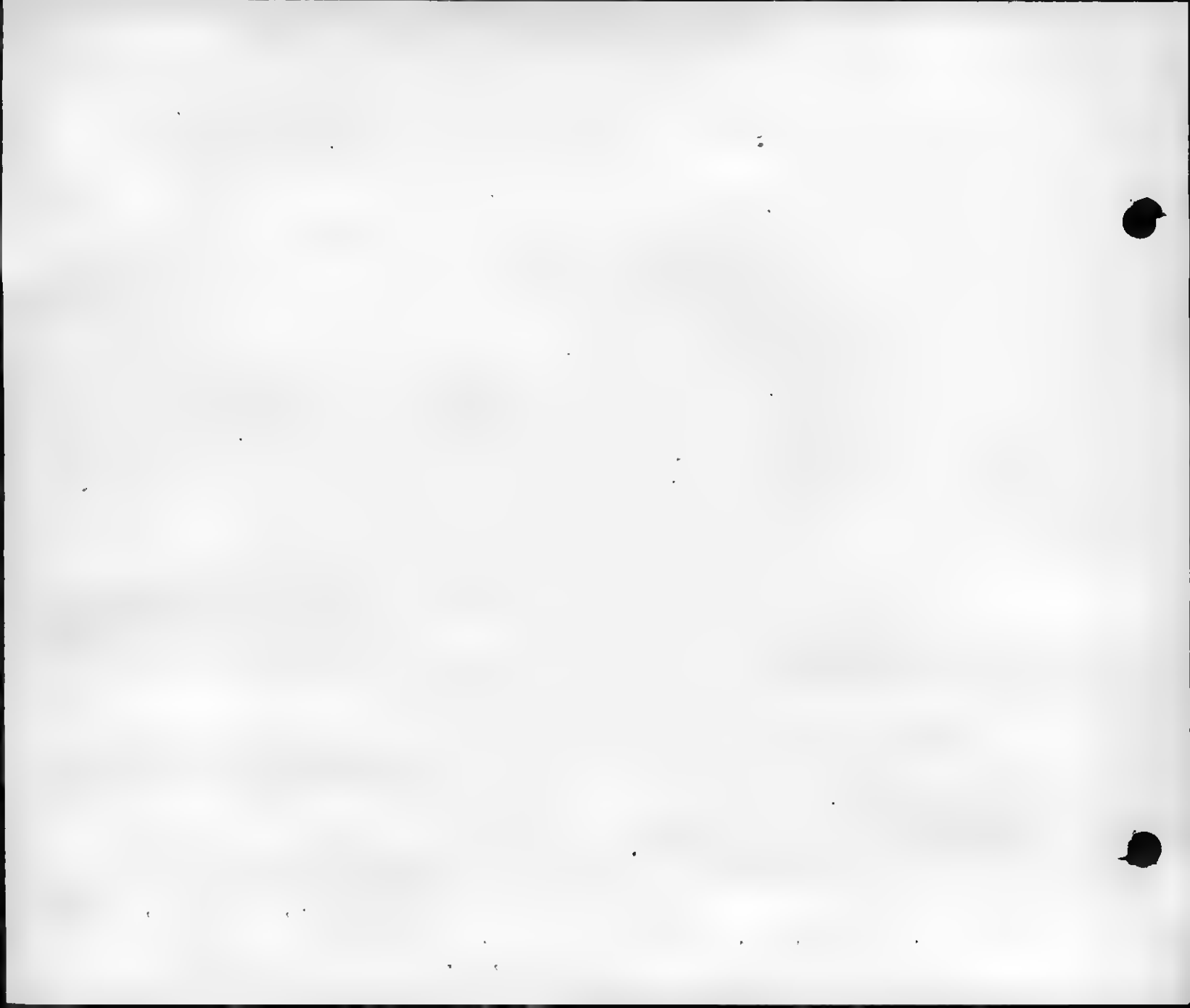
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>34 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11409 Maple View Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Naomi</u> Last <u>McNall</u>				4. DATE OF DEATH Month <u>May</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Daniel Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Naomi Dick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mr William F McNall, Sr some</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1959</u> to <u>May 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1961</u> , and that death occurred at <u>1215 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John Lawrence Avery</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>John Lawrence AVERY</u>				22d. ADDRESS <u>10110 Georgia Ave., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>5/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Montgomery, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> , Inc. 8434 Georgia Ave., Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE <u>MAY 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

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MD

5834

5821

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SAN.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>4106 Harvard St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First Middle Last		4. DATE OF DEATH <u>5-27-1961</u> Month Day Year	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>10-23-44</u> Yrs. Months Days	
9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE County & State, or foreign country <u>Roumania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. ISAAC Meltzer</u>		14. MOTHER'S MAIDEN NAME <u>Clara Gottfried</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>44-1093-09-5403</u>	
17. INFORMANT <u>Son (Jerome J. Meltzer) &amp; old Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Myocardial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I OR 19. WAS AUTOPSY PERFORMED? <u>Hypertension and arteriosclerotic heart disease</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <u>April</u> , 19 <u>61</u> to <u>May 27</u> , 19 <u>61</u> , that (i) ( <u>was</u> ) last saw the deceased alive on <u>May 27</u> , 19 <u>61</u> , and that death occurred at <u>2:30</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel T. Kunkel</u>		22b. DATE SIGNED <u>17 May 61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>927 Peaching Brim, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/29/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASH. CEM.</u>		23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick J. Bilson</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 31 '61</u>	
ADDRESS <u>417-9th St</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Hume</u>	



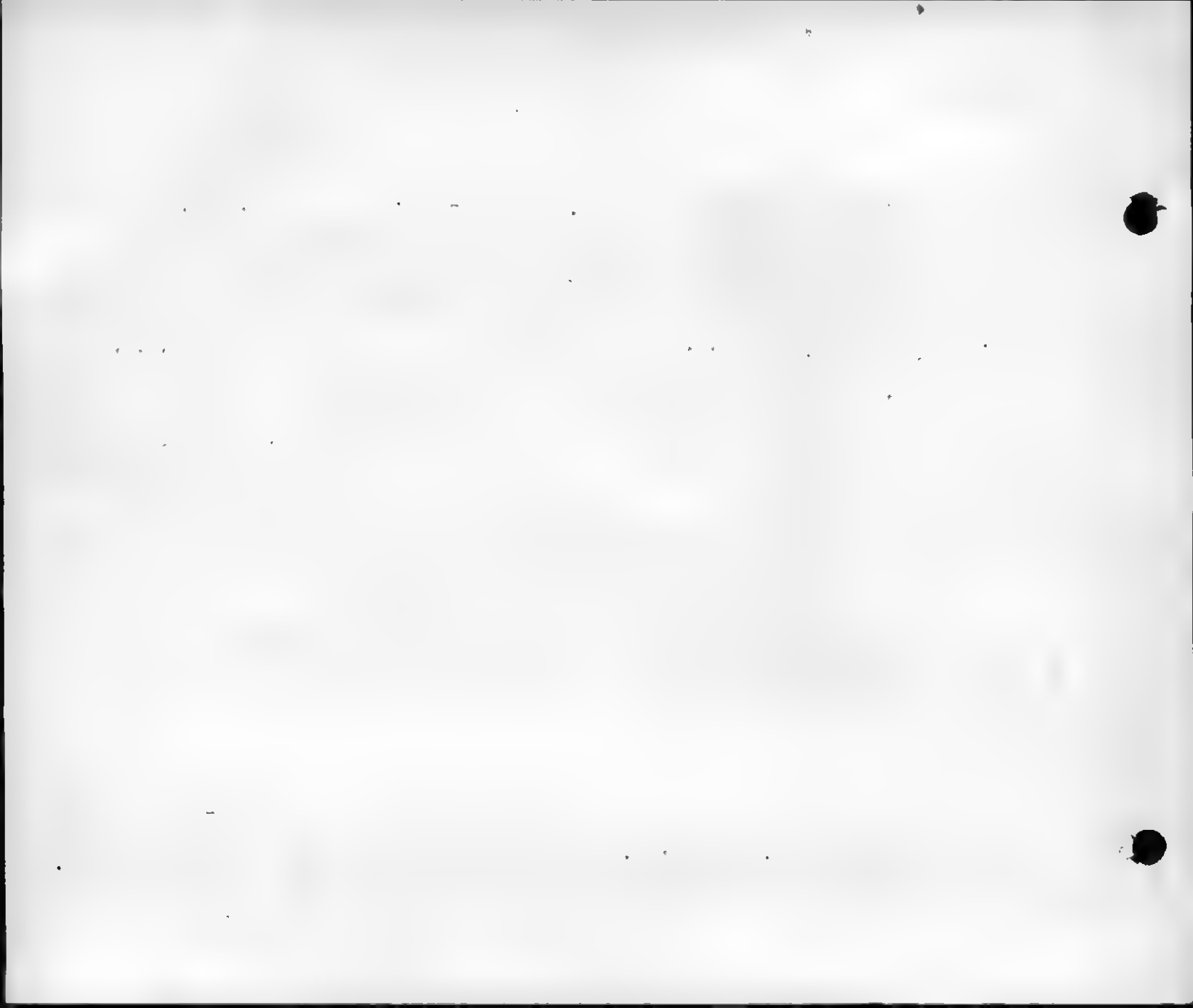
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5835

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05822

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>39 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3636 - 16th Street, N.W. Apt. A-815</b>			
3. NAME OF DECEASED (Type or print) First <b>Irvin</b> Middle <b>Fletcher</b> Last <b>Meyer</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 3, 1919</b>	
9. AGE (In years last birthday) yrs <b>41</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Actuary, Internal</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Revenue Emanuel M. Meyer</b>				14. MOTHER'S MAIDEN NAME <b>Julia Holzberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WALL</b>				16. SOCIAL SECURITY NO <b>Unascertainable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhagic Pneumonia</b> <b>204-3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>7 Months</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 12, 1961</b> to <b>May 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 21, 19 61</b> , and that death occurred at <b>9:30 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Vincent H. Bono Jr.</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>5-21-61</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Vincent H. Bono Jr. M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>5-23-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judo Toroa Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cincinnati, Ohio</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawrence Jones, Jr.</b>				25a. REC'D BY REGISTRAR <b>MAY 24 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Evans</b>	



TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

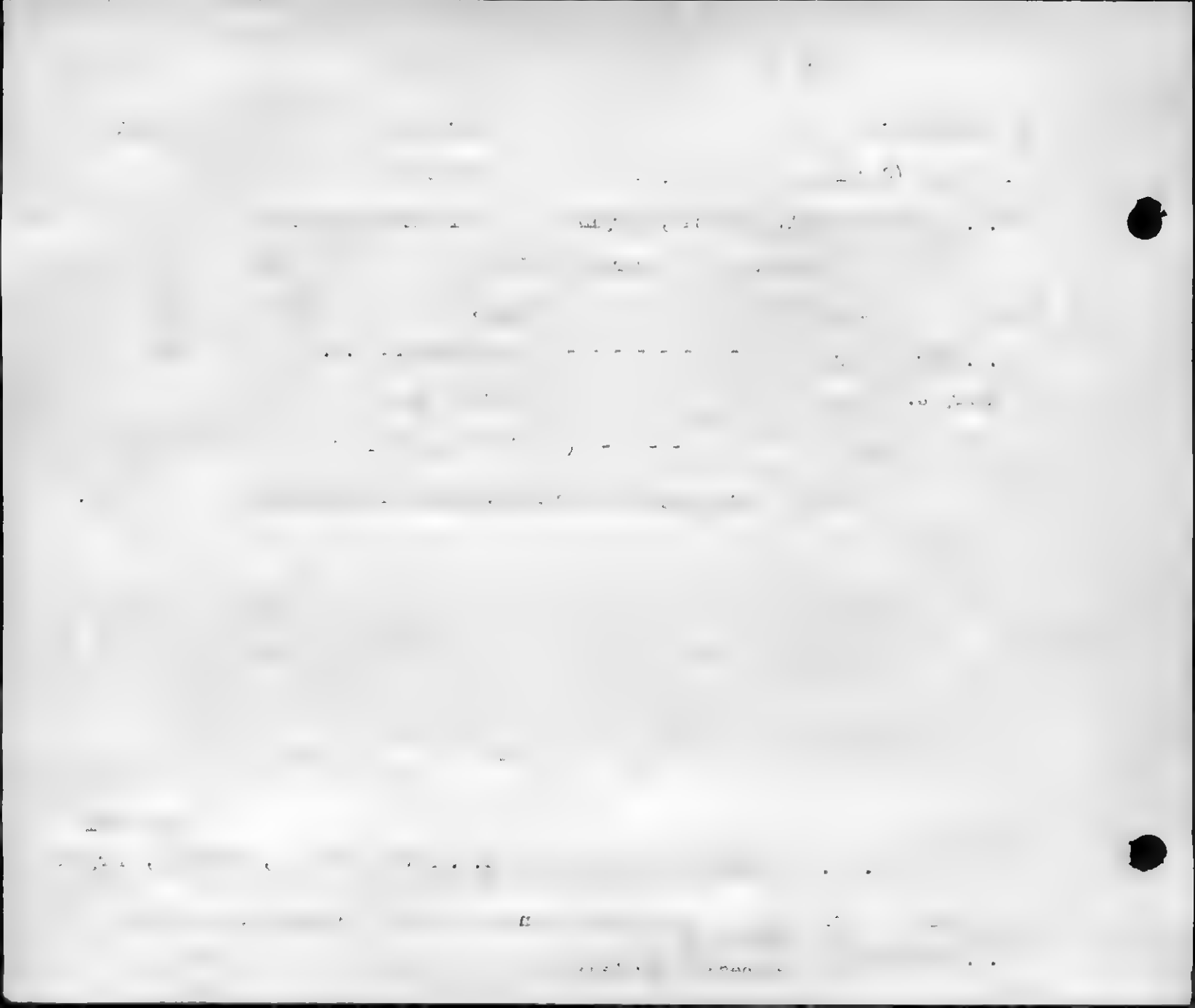
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5836

05823

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN b. <b>87 days</b>		d. STREET ADDRESS <b>5615 McKinley Street</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis Gerard MILLER</b>		4. DATE OF DEATH <b>May 27 1961</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2 August 1896</b>	
9. AGE (In years, last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D.C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry J. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Martha Upton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	
17. INFORMANT <b>(D) Miss Carol Miller</b>		Address <b>same as # 2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma, lung, with metastasis</b> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>3-1</b> 19 <b>61</b> to <b>5-27</b> 19 <b>61</b> , that (X) (we) last saw the deceased alive on <b>5-27</b> 19 <b>61</b> , and that death occurred at <b>355AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>F. H. O'Connell</b>		22b. DATE SIGNED <b>27 May 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LCDR, MC USN.S. Naval Hospital, Bethesda, Maryland</b>		22d. ADDRESS <b>557 Wisconsin Avenue Bethesda, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-31-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		25a. REC'D BY REG. STRAR <b>MAY 31 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			



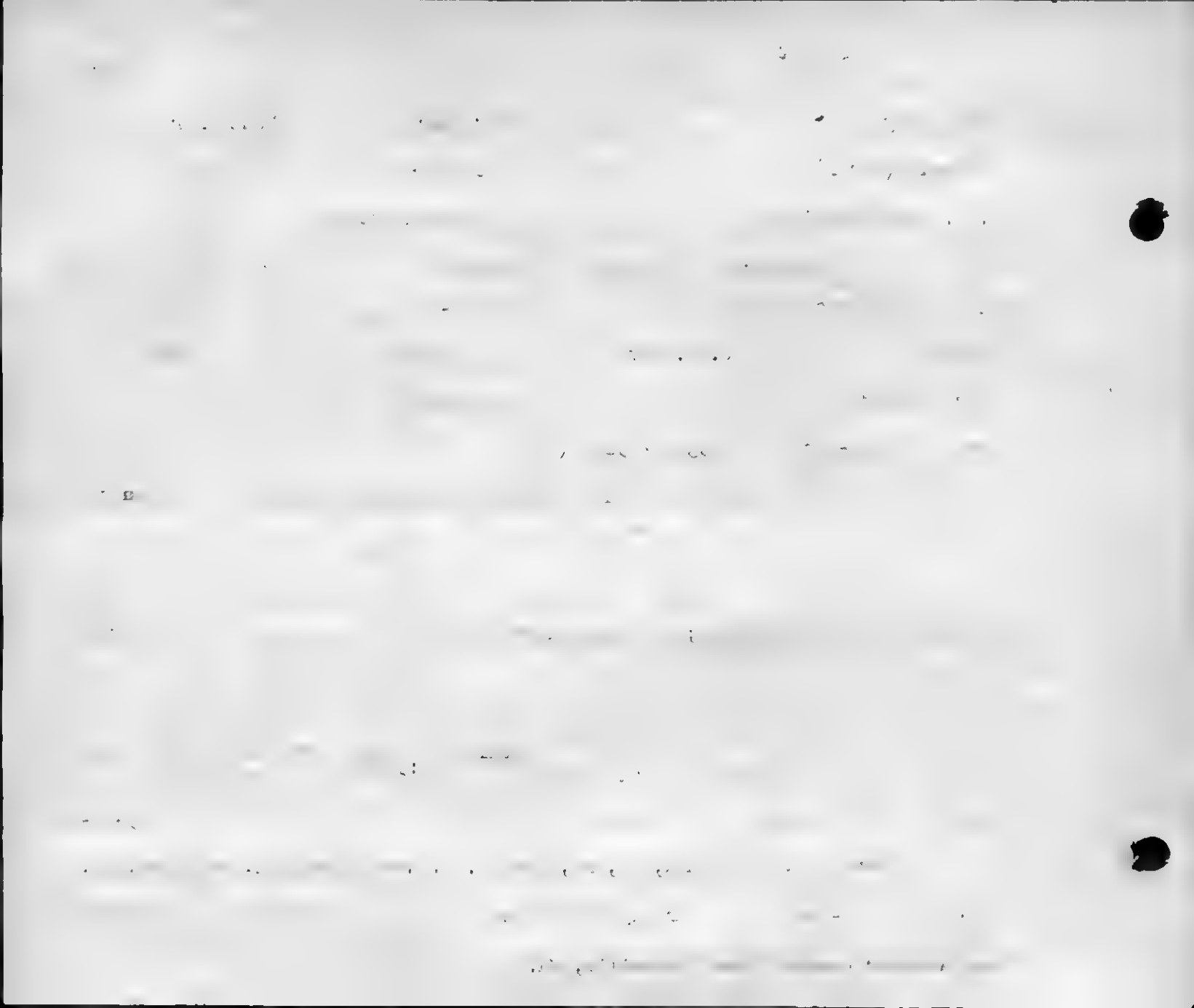
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05824

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>20 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>519 Beall Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Wagonen</b> First Middle Last <b>Male</b> 4. SEX <b>Male</b> 5. COLOR OR RACE <b>Caucasian</b> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>10-15-04</b> 9. AGE (In years IF UNDER 1 YEAR last birthday) Months Days Hours Min. <b>56</b> yrs <b>May 16</b> 19 <b>61</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b> 11. BIRTHPLACE (Country & State or foreign country) <b>Illinois</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Carl MINDTE</b> 14. MOTHER'S MAIDEN NAME <b>Lola FERN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WWII-Korean</b> 16. SOCIAL SECURITY NO <b>553-16-2519</b> 17. INFORMANT <b>(S)</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarct, posterior septal</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause led. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Calcific aortic stenosis; rt. upper lobe pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (X) (this hospital) attended the deceased from <b>April 26 8:50AM</b> to <b>May 16</b> , 19 <b>61</b> that (X) (we) last saw the deceased alive on <b>May 16</b> , 19 <b>61</b> , and that death occurred at <b>8:50AM</b> , from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <b>Kenneth V. Harshman</b> 22c. PHYSICIAN'S NAME (Type) <b>Kenneth V. HARSHMAN, LT, MC, USN</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22b. DATE SIGNED <b>5-16-61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>5-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b> ADDRESS <b>Tyson Wheeler Funeral Home, Rockville, Md.</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Tyson Wheeler</b>		25a. REC'D BY REG. STR. DATE <b>MAY 22 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY **Montgomery** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Bethesda (Rural)**  
c. LENGTH OF STAY IN b. **212 days**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **U. S. Naval Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **South Carolina**  
b. COUNTY **Orangeburg**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **416 Ellis Avenue**  
d. STREET ADDRESS **May 18 19 61**

3. NAME OF DECEASED (Type or print) **Edward MINTZ**  
First Last Middle  
4. DATE OF DEATH **May 18 19 61**  
Month Day Year  
5. SEX **Male**  
6. COLOR OR RACE **Negro**  
7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH **3-9-47**  
WIDOWED ☐ DIVORCED ☐ 9. AGE (in years): IF UNDER 1 YEAR: Last birthday) Months Days Hours Min. **14 yrs.**  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **South Carolina**  
10b. KIND OF BUSINESS OR INDUSTRY **USA**  
11. BIRTHPLACE (Country, State, and County) **USA**  
12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **Lonnie E. MINTZ**  
14. MOTHER'S MAIDEN NAME **Lillie Mae BILLY**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) **No**  
16. SOCIAL SECURITY NO. **None**  
17. INFORMANT **Hospital Records** Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) **Septicemia**  
DUE TO **Agranulocytosis**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **Malabsorption syndrome with rickets**

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐  
INTERVAL BETWEEN ONSET AND DEATH **4 days 1 month**

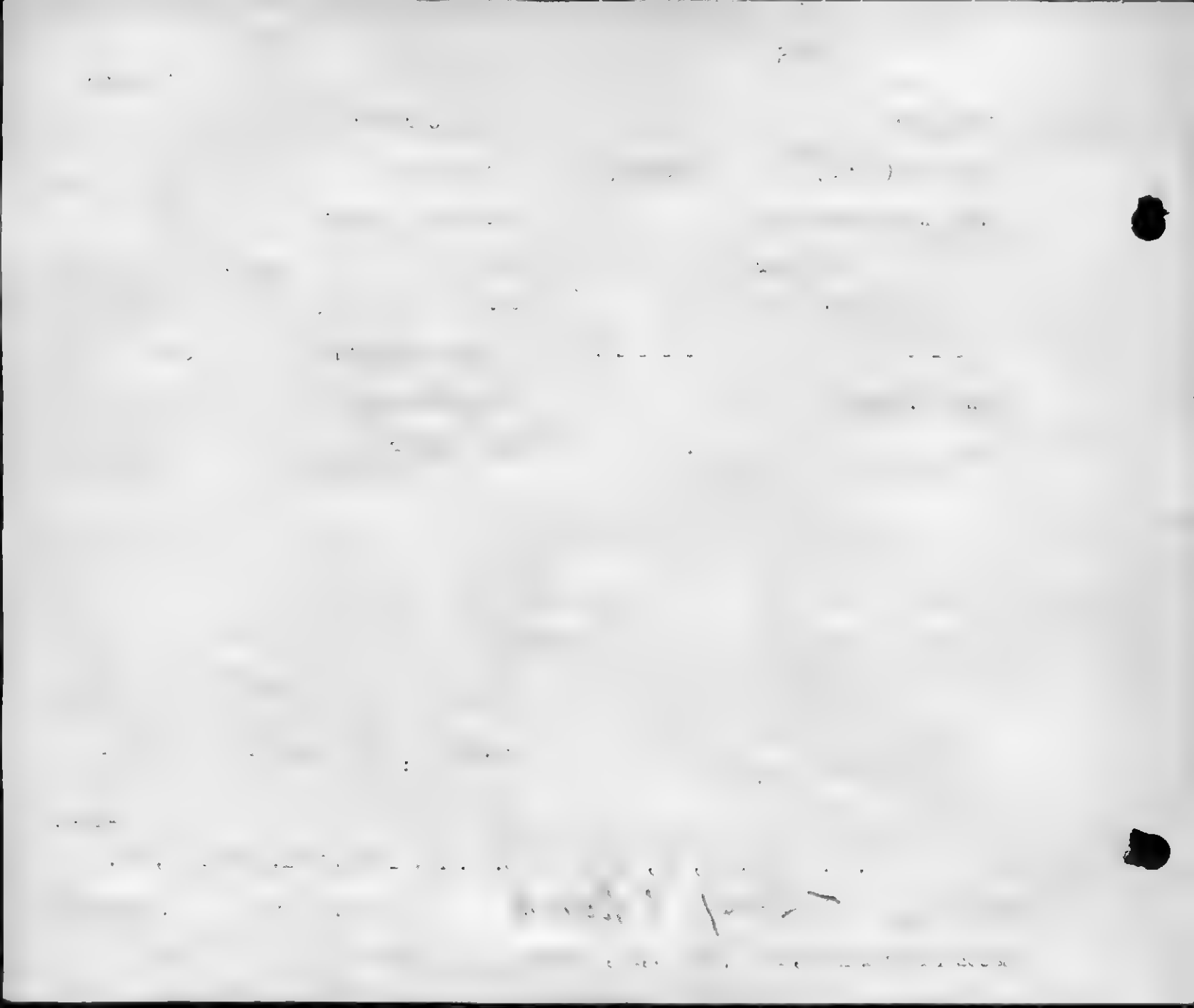
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐  
20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19**  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from **Oct. 18 19 60** to **May 18 19 61**, that ☒ (we) last saw the deceased alive on **May 18 19 61**, and that death occurred at **3:43AM**, from the causes and on the date stated above.

22a. SIGNATURE **G. B. Avery** M.D.  
22b. DATE SIGNED **5-18-61**  
22c. PHYSICIAN'S NAME (Type) **G. B. AVERY, LT, MC, USN**  
22d. ADDRESS **U. S. Naval Hospital, Bethesda, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial-Shipment**  
23b. DATE THEREOF **5-23-61**  
23c. NAME OF CEMETERY OR CREMATORY **Church**  
23d. LOCATION (City, town or county) (State) **Orangeburg So. Carolina**

24. FUNERAL DIRECTOR'S SIGNATURE **Bacon Funeral Home, 1722 7th St., NW, WashDC** ADDRESS  
25a. REC'D BY REGISTRAR **JUN 5 '61**  
25b. REGISTRAR'S SIGNATURE **Arthur L. Kline**



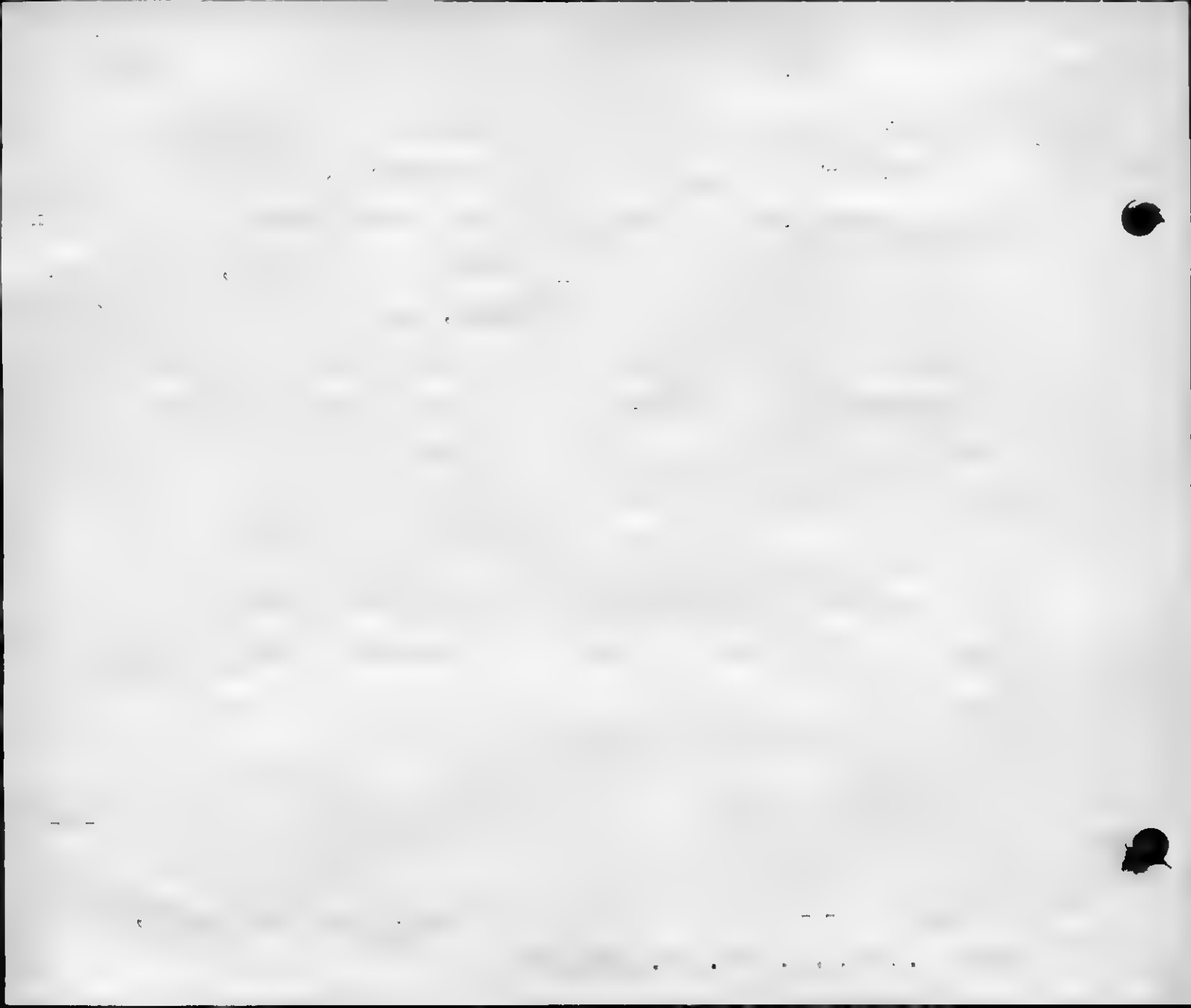
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The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5839

00978

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>8411 Galveston Road</b>		<b>3. NAME OF DECEASED</b> (Type or print) <b>Mitchell</b> First Middle Last <b>May 26, 1961</b> 9. AGE (in years last birthday) <b>May 26,</b> 19 <b>61</b> Months Days Hours Min. <b>2 55</b>	
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>none</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>none</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Maryland America</b> <b>12. CITIZEN OF WHAT COUNTRY</b> <b>America</b>		<b>13. FATHER'S NAME</b> <b>William Landon Mitchell</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Carol Darby</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>no</b> <b>17. INFORMANT</b> <b>mother</b> <b>18. CAUSE OF DEATH</b> (Enter only one cause or one for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Prematurity</b> <b>776X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> <b>(c)</b> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>(County)</b> <b>(State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>19</b> <b>to</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>19</b> <b>and that death occurred at</b> <b>M</b> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <b>H. H. Diamond</b> <b>22b. DATE SIGNED</b> <b>5-26-61</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>H. H. DIAMOND</b> <b>22d. ADDRESS</b> <b>911 - Silver Spring ave</b> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>23b. DATE THEREOF</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>23d. LOCATION (City, town or county)</b> <b>(State)</b> <b>Cremation</b> <b>6-8-61</b> <b>Washington Sanitarium and Hospital</b> <b>Takoma Park, Md</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Robert A. Hare, M. D. Wash. San. &amp; Hospital</b> <b>JUN 9 '61</b> <b>Arthur S. Hare</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring  
c. LENGTH OF STAY IN 1b 8 hrs.  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp.  
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MD. b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring  
d. STREET ADDRESS 10510 Greenacres Dr.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒  
3. NAME OF DECEASED (Type or print) Lillian Ella Moon  
4. DATE OF DEATH 5-23-1961  
5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH 7-27-99 9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min. IF UNDER 24 HRS. 10 Hrs. 5 Mins. 10 Secs.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby sitter  
10b. KIND OF BUSINESS OR INDUSTRY Ry.  
11. BIRTHPLACE (County & State, or foreign country) N.Y.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.  
13. FATHER'S NAME Ernest Due 14. MOTHER'S M.A.DEN NAME Johanna Schaefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? no 16. SOCIAL SECURITY NO. no 17. INFORMANT Germany  
(Yes, no, or unknown) (If yes, give year or date of service)

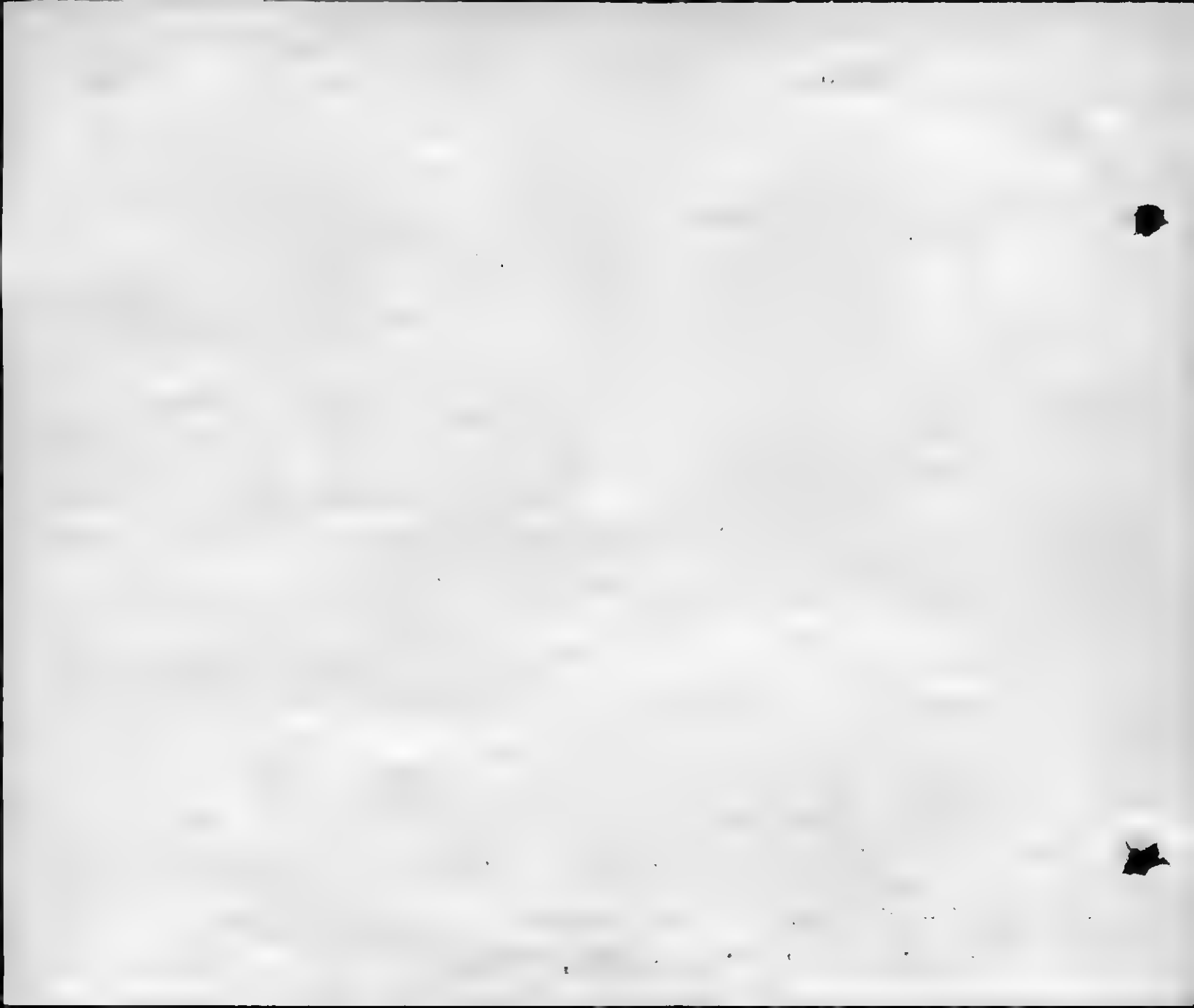
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Massive cerebral Hemorrhage  
331X DUE TO  
Conditions if any, which gave rise to immediate cause (b) Cerebral vascular disease  
(c), stating the underlying cause last. DUE TO Mild vascular Hypertension  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None  
INTERVAL BETWEEN ONSET AND DEATH 9 hrs.  
5-10 yrs.  
10+ yrs.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ☐  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year March 19, 1961  
Hour a.m. — p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —  
20f. (City or town) — (County) — (State) —

21. I certify that (I) (~~this hospital~~) attended the deceased from March 19, 1961 to May 23, 1961, that (I) (~~we~~) last saw the deceased alive on May 23, 1961, and that death occurred 8:50 PM, from the causes and on the date stated above.  
22a. SIGNATURE J. Frederick Barr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 5-25-61  
22c. PHYSICIAN'S NAME (Type) J. Frederick BARR, MD 22d. ADDRESS 4500 College Ave, College Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 23b. DATE THEREOF 5/28/61 23c. NAME OF CEMETERY OR CREMATORY Hudson Cemetery 23d. LOCATION (City, town or county) Hudson Iowa (State) Iowa  
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Maryland  
25a. REC'D BY REGISTRAR MAY 29 '61 25b. REGISTRAR'S SIGNATURE William S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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FOR STATE  
HEALTH DEPT.

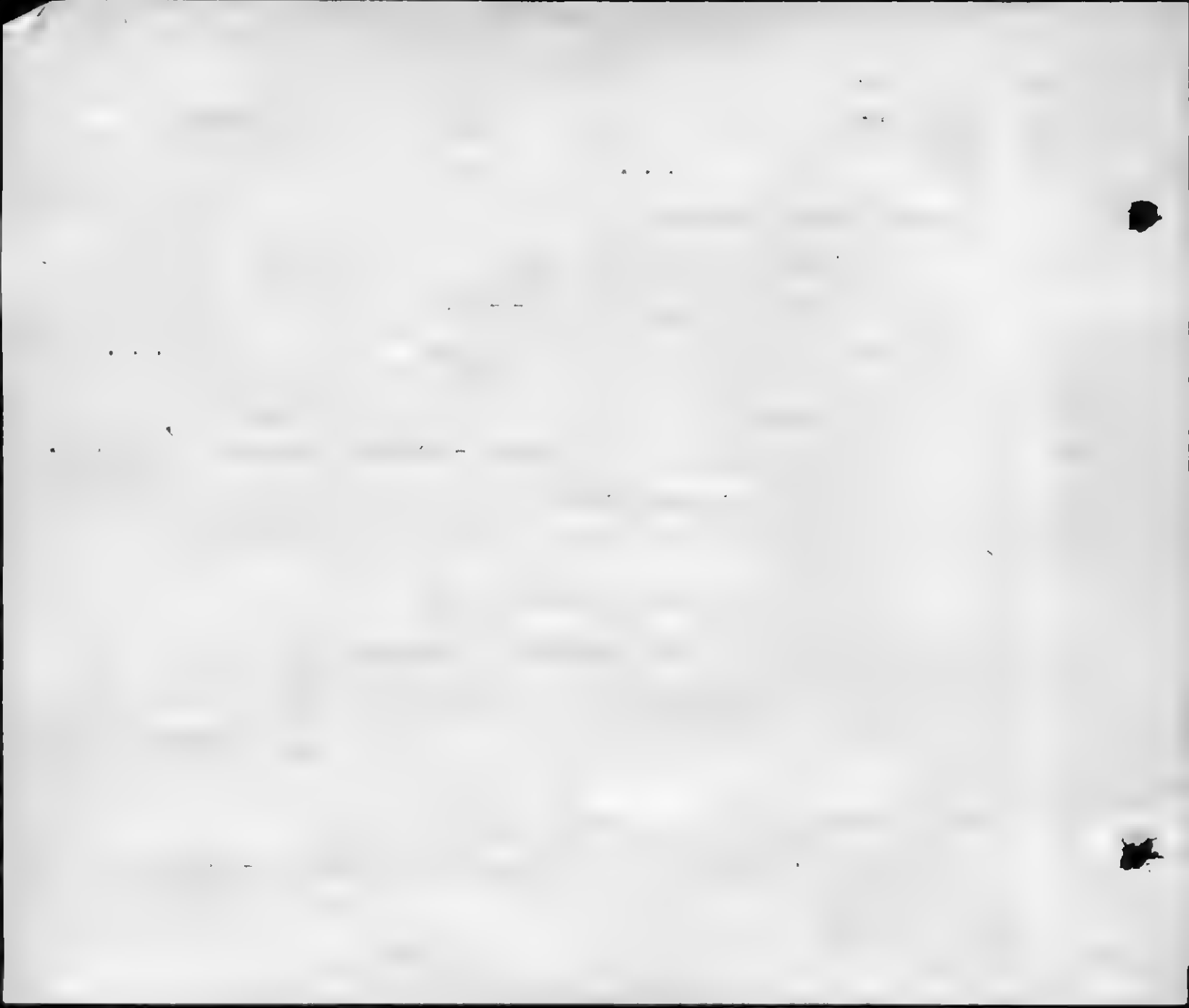
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5827

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashton</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CORDELIA FRANCES MOORE</b>		4. DATE OF DEATH Month <b>May</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-1-1887</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>27</b>	
11. IF UNDER 24 HRS Hours <b>19</b> Min. <b>61</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>1021 Briggs Chaney Road, Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>420-1</b> DUE TO (c) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>5-27-61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 31, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Peck Legion Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Rockville Montg Co - Md.</b>	
23. FUNERAL DIRECTOR <b>Arthur Walters</b>		24a. REC'D BY REG. STRAR <b>MAY 31 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>		24c. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.





TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

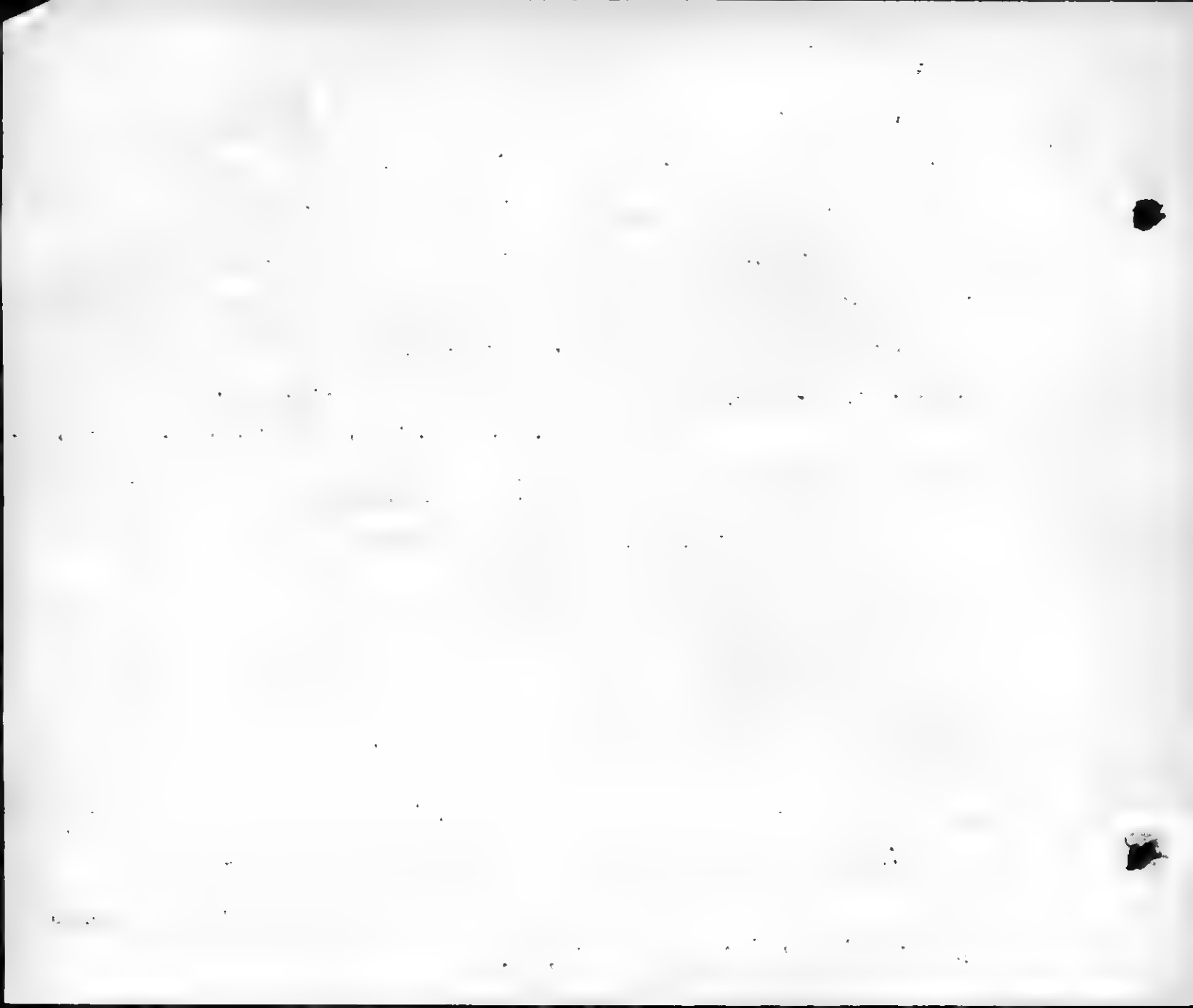
5842

CERTIFICATE OF DEATH

Reg. Dist. No. 05828

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (For de corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>606 University Blvd, West</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Teresa</u> Last <u>Moran</u>				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1905</u>	
9. AGE (In years, last birthday) <u>56 yrs</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Internal Revenue</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Maurice E. O'Connor</u>				14. MOTHER'S MAIDEN NAME <u>Katie M. Wheatley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>416X Congestive heart failure</u> DUE TO (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>30 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
19a. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		19d. CITY or town (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>Sept 24, 1956</u> , to <u>May 30, 1961</u> , that I last saw the deceased alive on <u>May 30, 1961</u> , and that death occurred at <u>8:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D.				ADDRESS (Street, city or town, state) <u>345 University Blvd, West Silver Spring, Md</u>		DATE SIGNED <u>5/30/61</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/2/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
5843												
05824												
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN IN <u>13 months</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						
3. NAME OF DECEASED (Type or print) First <u>Narolyn</u> Middle <u>Day</u> Last <u>Nau</u>						4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1961</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 17-1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>				
13. FATHER'S NAME <u>C. Edward Day</u>						14. MOTHER'S MAIDEN NAME <u>Edith V. Laird</u> Deceased						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Mabel Ames</u> Address <u>1018 Woodside Pkwy, SS</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } b <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>10 years</u>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1951</u> to <u>May 1, 1961</u> , that (I) (we) last saw the deceased alive on <u>April 30, 1961</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.												
22a. SIGNATURE <u>James M. Whitlock</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-1-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>						22d. ADDRESS <u>7717 Carroll Ave, Takoma Park, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 3, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Prince George County Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>						ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

1000 1000 1000

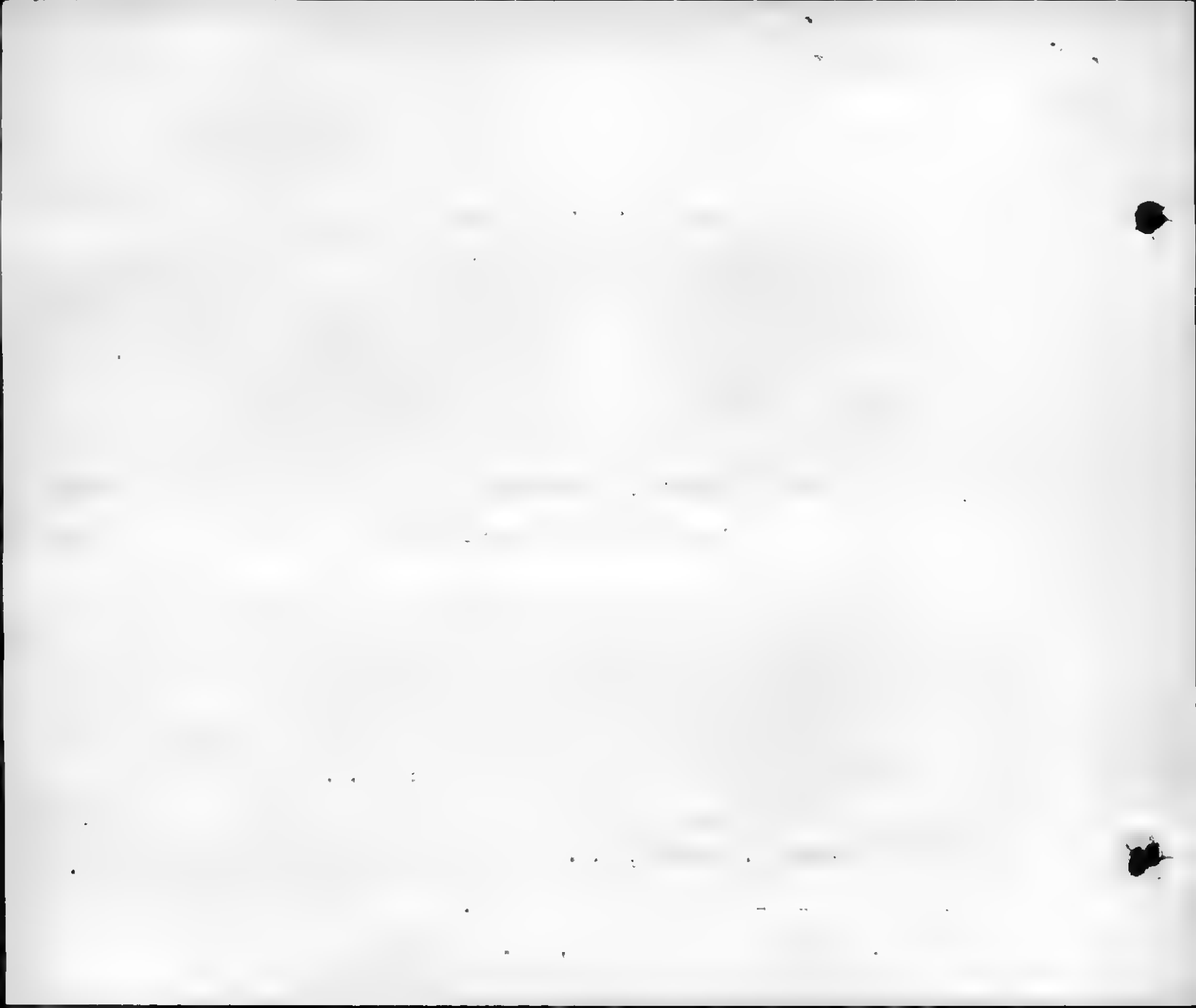
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5844

05831

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Norfolk</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>24 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>(None)</b> Last <b>Nichols</b>				4. DATE OF DEATH Month <b>May</b> Day <b>18</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 28, 1913</b>	
9. AGE (in years last birthday) <b>47</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>17</b> Hours <b>17</b> Min <b>17</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>John Tsoukatos</b>				14. MOTHER'S MAIDEN NAME <b>Constance Kalodimas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>17 4X</b> DUE TO (b) <b>Mixed mesodermal Tumor of Uterus</b> DUE TO (c) <b>8 months</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that <b>14</b> (this hospital) attended the deceased from <b>April 24</b> , 19 <b>61</b> , to <b>May 18</b> , 19 <b>61</b> , that <b>79</b> (we) last saw the deceased alive on <b>May 18</b> , 19 <b>61</b> , and that death occurred on <b>May 18</b> , 19 <b>61</b> , and the causes and on the date stated above 22a. SIGNATURE <b>Benjamin A. Borowsky</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE <b>5/18/61</b> 22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN A. BOROWSKY, M.D.</b> 22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		23b. DATE THEREOF <b>5-18-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Lawn Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Norfolk, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 23 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

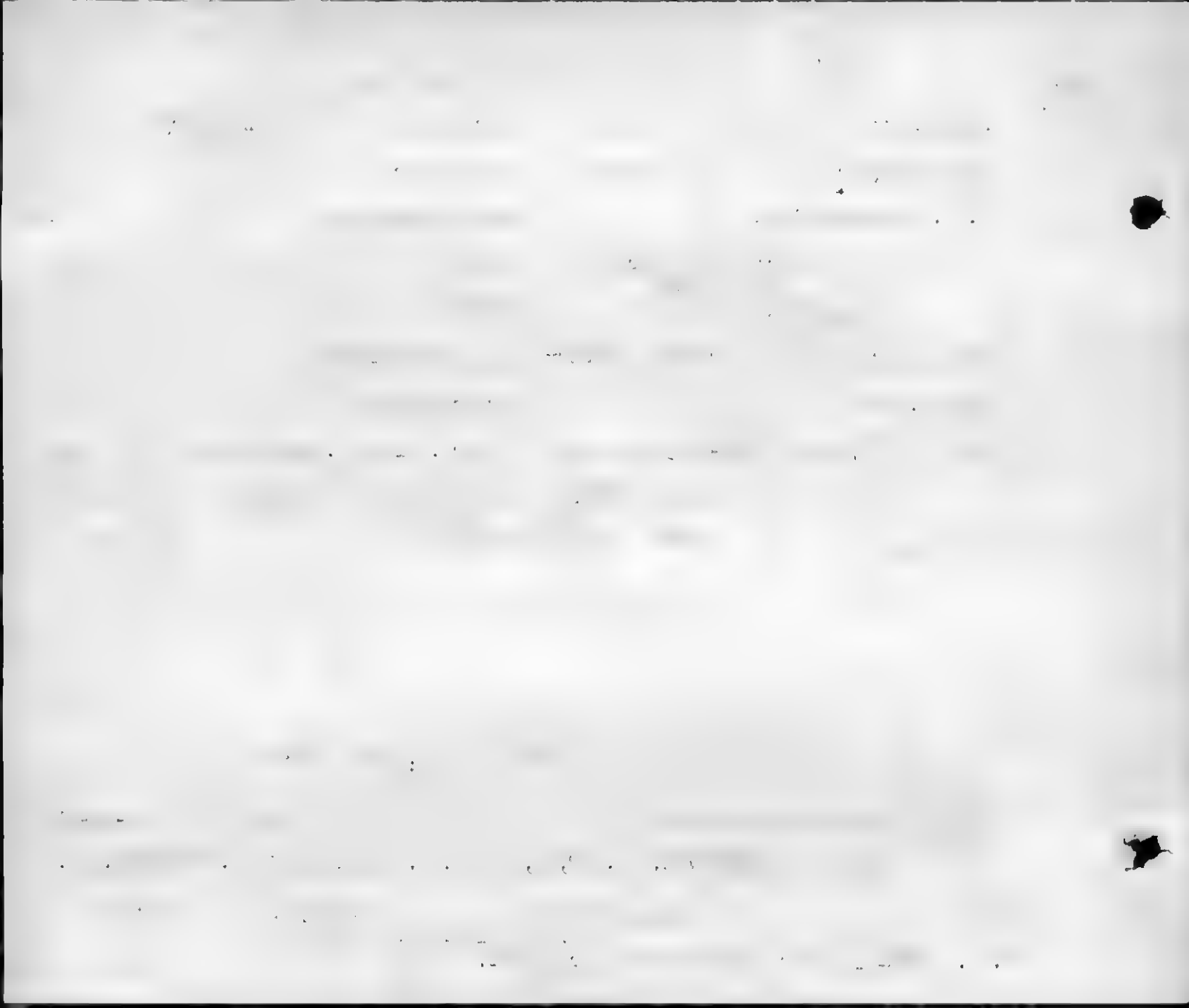
Item 23b File # 6288 6/12/61

5845

05832

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>39 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>8405 Dixon Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mark Leroy NOLL</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>19 61</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>12-25-99</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steamfitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Industry</b>		11. BIRTH-PLACE (County & State, or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Elmer S. NOLL</b>		14. MOTHER'S MAIDEN NAME <b>Margaret BARTHO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>7-17-17 to 8-12-19 579-14-5616</b>		17. INFORMANT <b>(W) Mrs. Flora L. Noll, same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>metastatic carcinoma of the bronchus</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. (City or town) <b>April 19 1961</b>	
21. I certify that <b>he</b> (th's hospital) attended the deceased from <b>April 19 1961</b> to <b>May 28 1961</b> , that <b>he</b> (we) last saw the deceased alive on <b>May 28 1961</b> , and that death occurred at <b>4:10PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Paul G. Linaweaver, Jr.</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Paul G. LINAWEAVER, JR., LT, MC, USN U. S. Naval Hospital, Bethesda, Md.</b>		22b. DATE SIGNED <b>5-29-61</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THERE <b>June 1, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Humphrey</b>		ADDRESS <b>Silver Spring, Md.</b>		25. REC'D BY REGISTRAR <b>JUN 5 '61</b>	
25a. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





5846

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

65833

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		d. STREET ADDRESS <u>6311 Kirby Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM S. OFFENHEISER</u>		4. DATE OF DEATH Month Day Year <u>5 25 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/182</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engraver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles J. Offenheiser</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hopper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>William F. Offenheiser-son-same</u>		Address <u>2d</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RENAL FAILURE &amp; UREMIA</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 WEEKS</u> <u>8 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 1957</u> to <u>MAY 25, 1961</u> , that (I) (we) last saw the deceased alive on <u>5 23 1961</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip R. James</u>		22b. DATE SIGNED <u>5/25/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PHILIP R. JAMES</u> <u>Ph. Philip R. James</u>		22d. ADDRESS <u>WASHINGTON CLINIC, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 5/27/61</u>		23b. DATE THEREOF _____	
23c. NAME OF CEMETERY OR CREMATORY <u>South Church Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bergenfield, New Jersey</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>MAY 29 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

158834

1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b 18 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND  
b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 4512 Leland St  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) CARRIE  
First Middle Last  
4. DATE OF DEATH May 20 1961  
Month Day Year

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH (1880) 7/24/80  
WIDOWED ☒ DIVORCED ☐ 9. AGE (In years if under 1 year, if under 24 hrs. last birthday) 80 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AWF 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND 11. BIRTHPLACE (County & State, or foreign country) U.S. 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME FRANK B. CORE 14. MOTHER'S MAIDEN NAME CAROLINE Wilhelm  
Address Bethesda

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. — 17. INFORMANT (Son) LESTER Phipps Address 4512 Leland St.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Pulmonary Embolism  
Conditions, if any, which gave rise to immediate cause (b) Peripheral Venous thrombosis  
(a), stating the underlying cause last, (c) unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐  
Cerebral infarction, cerebral thrombosis, left middle cerebral artery

20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20b. INJURY OCCURRED While at work ☐ Not While at work ☐ 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. (City or town) (County) (State)

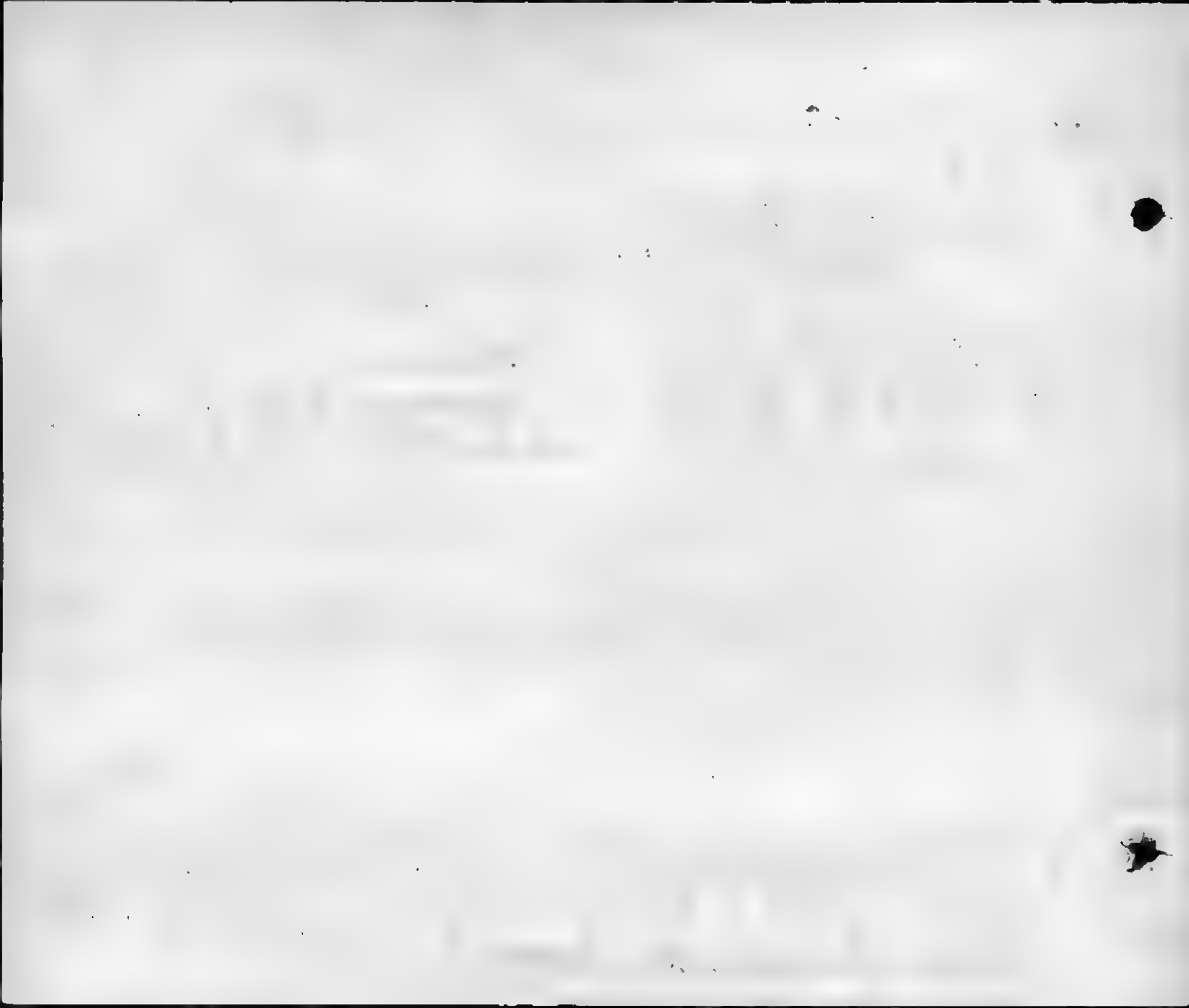
21. I certify that (I) (this hospital) attended the deceased from 2 May, 1961, to 5/20, 1961, that (I) (we) last saw the deceased alive on 20 May, 1961, and that death occurred at 12:30 PM, from the causes and on the date stated above.

22a. SIGNATURE John G. Boll M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED May 23 '61

22c. PHYSICIAN'S NAME (Type) John G. Boll 22d. ADDRESS 7936 Old Georgetown Rd, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5-24-61 23c. NAME OF CEMETERY OR CREMATORY Middletown Cemetery 23d. LOCATION (City, town or county) (State) Freeland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE J. Jacob Kortenstein ADDRESS New Freedom, Pa. 25a. REC'D BY REGISTRAR MAY 23 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

Items 8 & 9 fill out 5855

1. PLACE OF DEATH  
a. COUNTY **Montgomery** MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kensington**  
c. LENGTH OF STAY IN b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **3824 Denfeld ~~Street~~ Ave.**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **Maryland** b. COUNTY **Montgomery**  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Kensington**  
d. STREET ADDRESS **3824 Denfeld ~~Street~~ Ave.**  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **ROBERT SLADE PLOWMAN**  
4. DATE OF DEATH **May 4, 1961**  
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **Apr. 11, 1883** 9. AGE (In years, months, days) **77 yrs.** IF UNDER 1 YEAR Months Days Hours M'n. **23**  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Siderographer - Retired** 10b. KIND OF BUSINESS OR INDUSTRY **New York** 11. BIRTHPLACE County & State or for a country **U. S.** 12. CITIZEN OF WHAT COUNTRY?

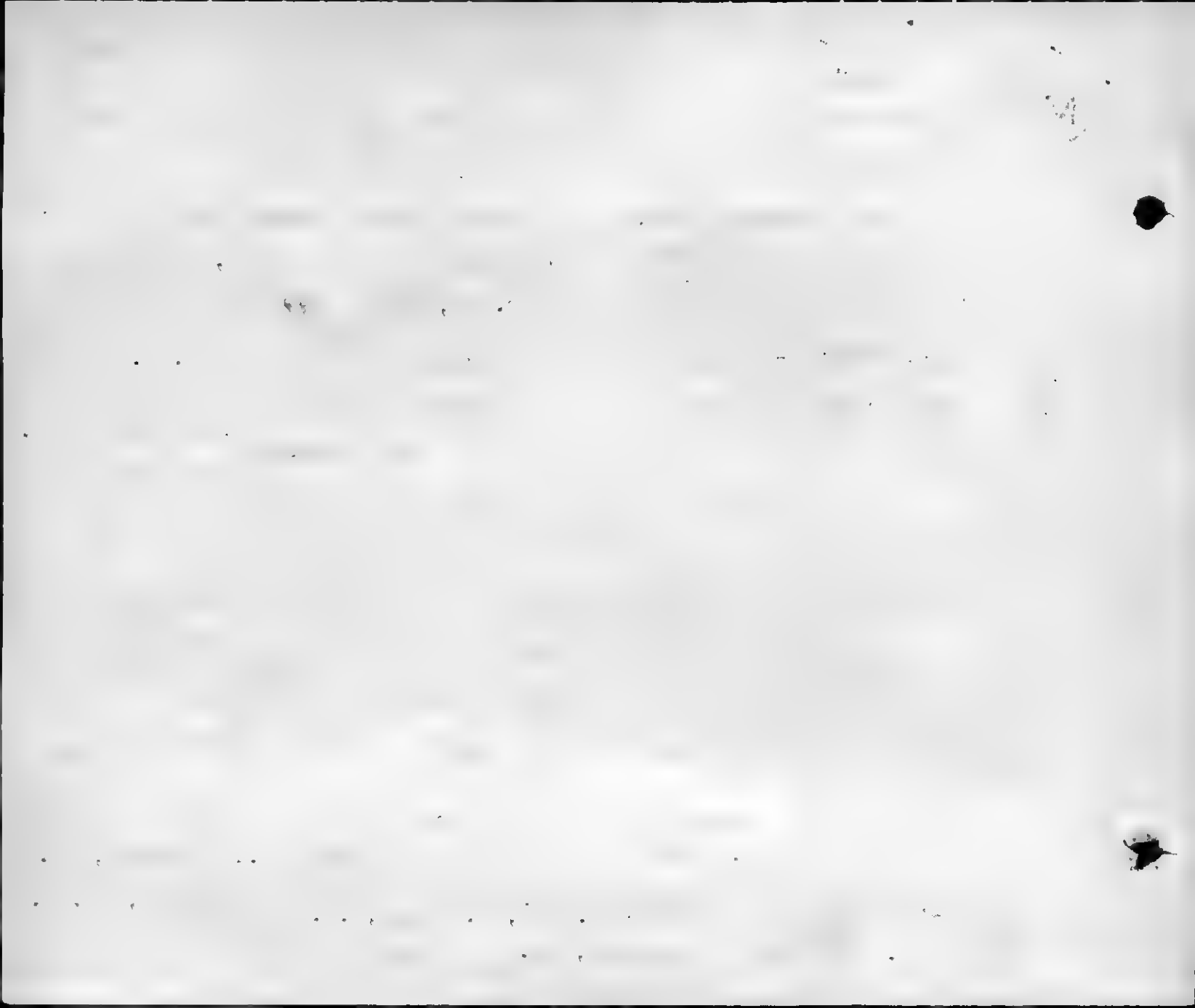
13. FATHER'S NAME **Samuel James Plowman** 14. MOTHER'S MAIDEN NAME **Isabel Perine**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **No** 16. SOCIAL SECURITY NO **Adelaide Cobb Plowman** 17. INFORMANT **Wife** Address **Same as Item 2.**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Right Heart Failure**  
DUE TO (b) **Emphysema - chronic bronchitis**  
DUE TO (c) **20 yrs.**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year **19** 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ el work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (the medical) attended the deceased from **March, 1951**, to **5-4, 1961**, that (I) (we) last saw the deceased alive on **5-4, 1961**, and that death occurred at **7 P.M.** from the causes and on the date stated above.  
22a. SIGNATURE **Alfred S. Norton** M.D. 22b. DATE **May 5, 1961**  
22c. PHYSICIAN'S NAME (Type) **ALFRED S. NORTON** 22d. ADDRESS **4711 Highland Ave., Bethesda, Md.**  
23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial-transit 5/9/61** 23b. DATE THE 23c. NAME OF CEMETERY OR CREMATORY **Woodlawn Cem. via Burr Davis Fun. Home, Mt. Vernon, N.Y.** 23d. LOCATION (City, town or county) (State) **New York City, N. Y.**  
24. FUNERAL DIRECTOR'S SIGNATURE **ROBERT A. PUMPHREY** ADDRESS **Bethesda, Md.** 25a. REC'D BY REGISTRAR **MAY 9 '61** 25b. REGISTRAR'S SIGNATURE **Wm. L. Travis**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

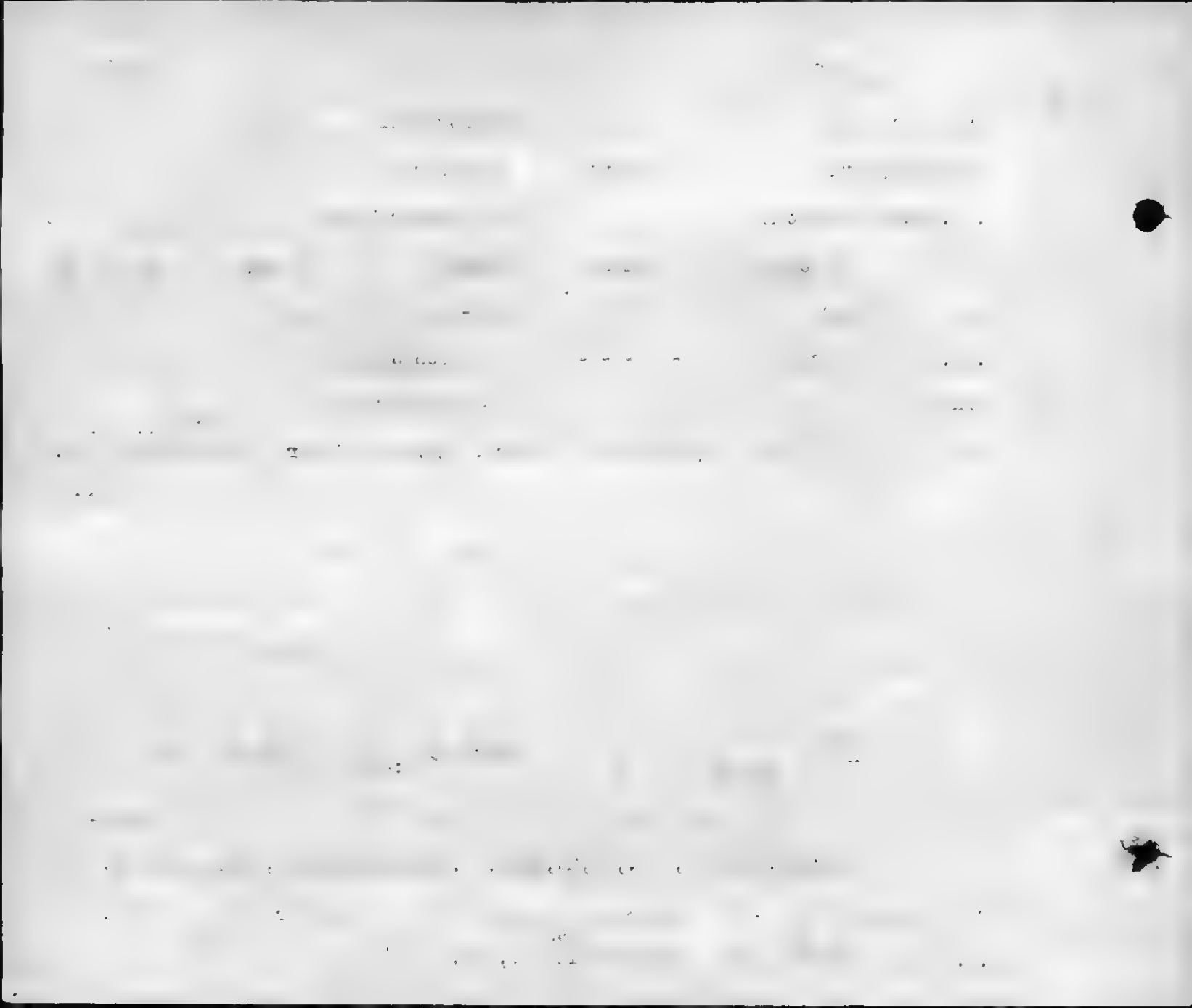


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>61 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Pittsburg</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>567 Singer Place</b> d. STREET ADDRESS <b>75 Y -</b>	
3. NAME OF DECEASED (Type or print) <b>John Allen PRUNTY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>2-10-39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Marine Corps</b>		9. AGE (in years last birthday) <b>22 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Marine Corps</b>		11. BIRTHPLACE (Country & State or foreign country) <b>Pennsylvania</b>	
11. BIRTHPLACE (Country & State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Clevetta PRUNTY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes 1956 to DOD</b>		16. SOCIAL SECURITY NO <b>176-32-0535</b>	
17. INFORMANT <b>(M) Mrs. Clevetta Wilborn, 172 Mayflower St.</b>		Address <b>Pitts., Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephroblastoma, Right Kidney</b> DUE TO (b) <b>metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>10</del> (this hospital) attended the deceased from <b>March 25, 1961</b> to <b>May 25, 1961</b> that (ix) (we) last saw the deceased alive on <b>May 25, 1961</b> , and that death occurred at <b>1:45 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Robert T. Brooks, Jr., M.D.</b>	
22b. PHYSICIAN'S NAME (Type) <b>Robert T. Brooks, Jr., LT, MC, USNU, S. Naval Hospital, Bethesda, Md.</b>		22c. ADDRESS <b>WashDC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 5-26-61</b>		23b. DATE THEREOF <b>5-26-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Pittsburg Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Funeral Home, 1400 Chapin St., NW,</b>		25a. REC'D BY REG. STRAR DATE <b>MAY 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		25c. DATE <b>MAY 29 '61</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

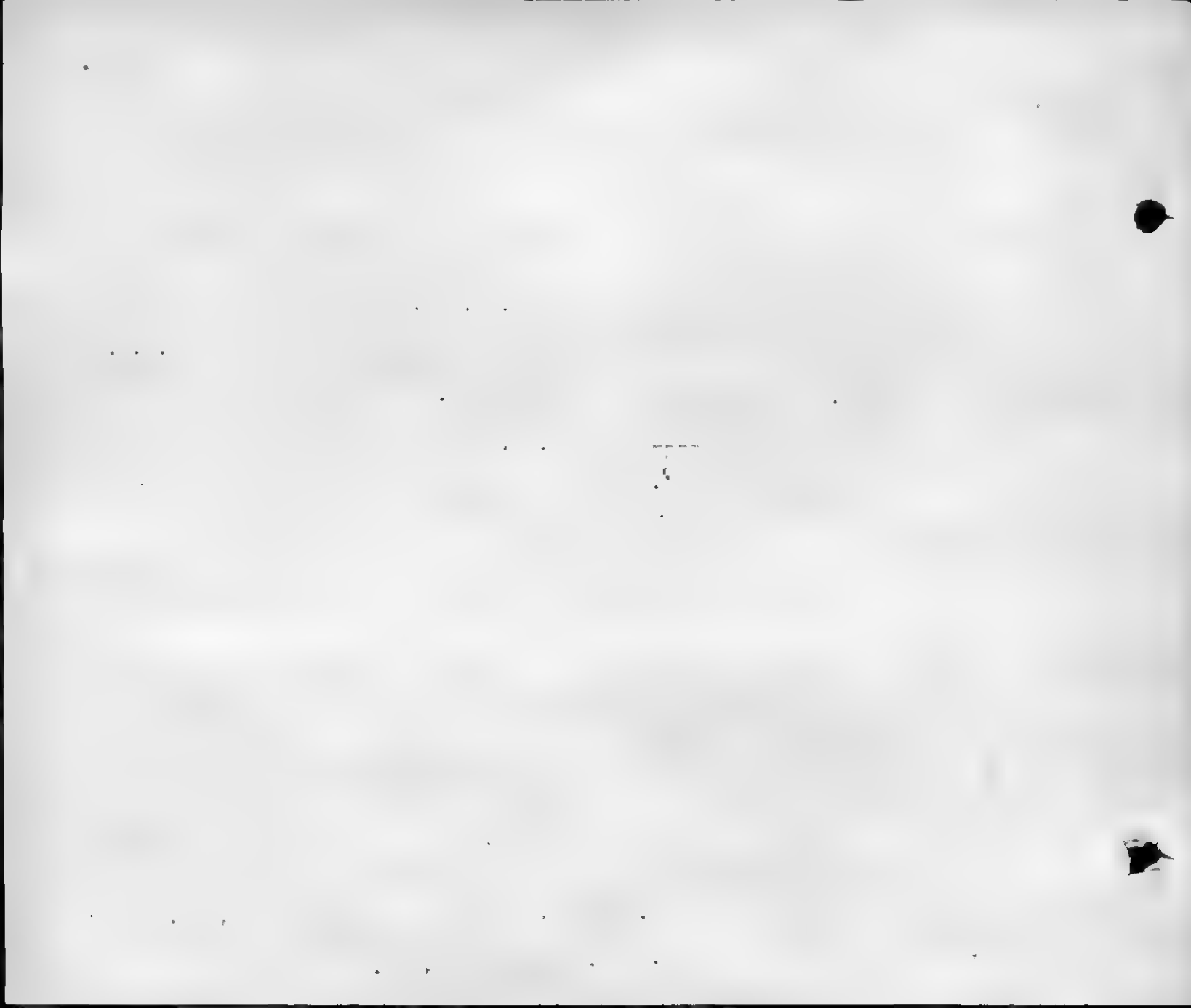
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M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
5850											
05807											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1135 Loxsford Terrace</b>					
3. NAME OF DECEASED (Type or print) <b>Thelma Elizabeth Pyle</b>						4. DATE OF DEATH <b>May 11 1961</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 24, 1907</b>		9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Arthur M. Anderson</b>						14. MOTHER'S MAIDEN NAME <b>Uda G. Remington</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>--66--</b>		17. INFORMANT <b>Wm. H. Pyle</b>		Address <b>Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153X</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Carcinoma of colon.</b> DUE TO (c) <b>11 mos.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>5/11/61</b> that (I) (we) last saw the deceased alive on <b>5/4/61</b> and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Donald Nelson</b> M.D.						22b. DATE SIGNED <b>5/11/61</b>					
22c. PHYSICIAN'S NAME (Type) <b>Donald Nelson</b>						22d. ADDRESS <b>1000 Georgia Ave Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>5/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>						ADDRESS <b>4739 Balt. Ave. Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 18 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kenna</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5851

05839

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>40 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> <span style="float:right">b. COUNTY <b>Prince Georges</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b> d. STREET ADDRESS <b>Box 1236</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Deborah Lynn Randall</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 61</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1958</b>		9. AGE (In years last birthday) <b>3</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>			
13. FATHER'S NAME <b>David E. Randall, Jr.</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Thomas</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atelectasis Right Medial Lobe and Left Upper Lobe and extensive Pneumonitis.</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cystic Fibrosis of the Pancreas</b>							
(c) <b>Diffuse Emphysema; Respiratory acidosis</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2-3 Weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 13, 19 61</b> to <b>May 23, 19 61</b> , that (I) (we) last saw the deceased alive on <b>May 23, 19 61</b> , and that death occurred on <b>May 23, 19 61</b> at <b>12:15 am</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>HUGH E. EVANS, M.D.</b>		22b. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22c. DATE SIGNED <b>5-23-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>HUGH E. EVANS, M.D.</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried May 25-61</b>		23b. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23c. LOCATION (City, town, or county) (State) <b>Suitland Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Sumner Bros.</b>		25a. REC'D BY REGISTRAR <b>1661- Good Hope Rd SE WASH 20 DC</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5852

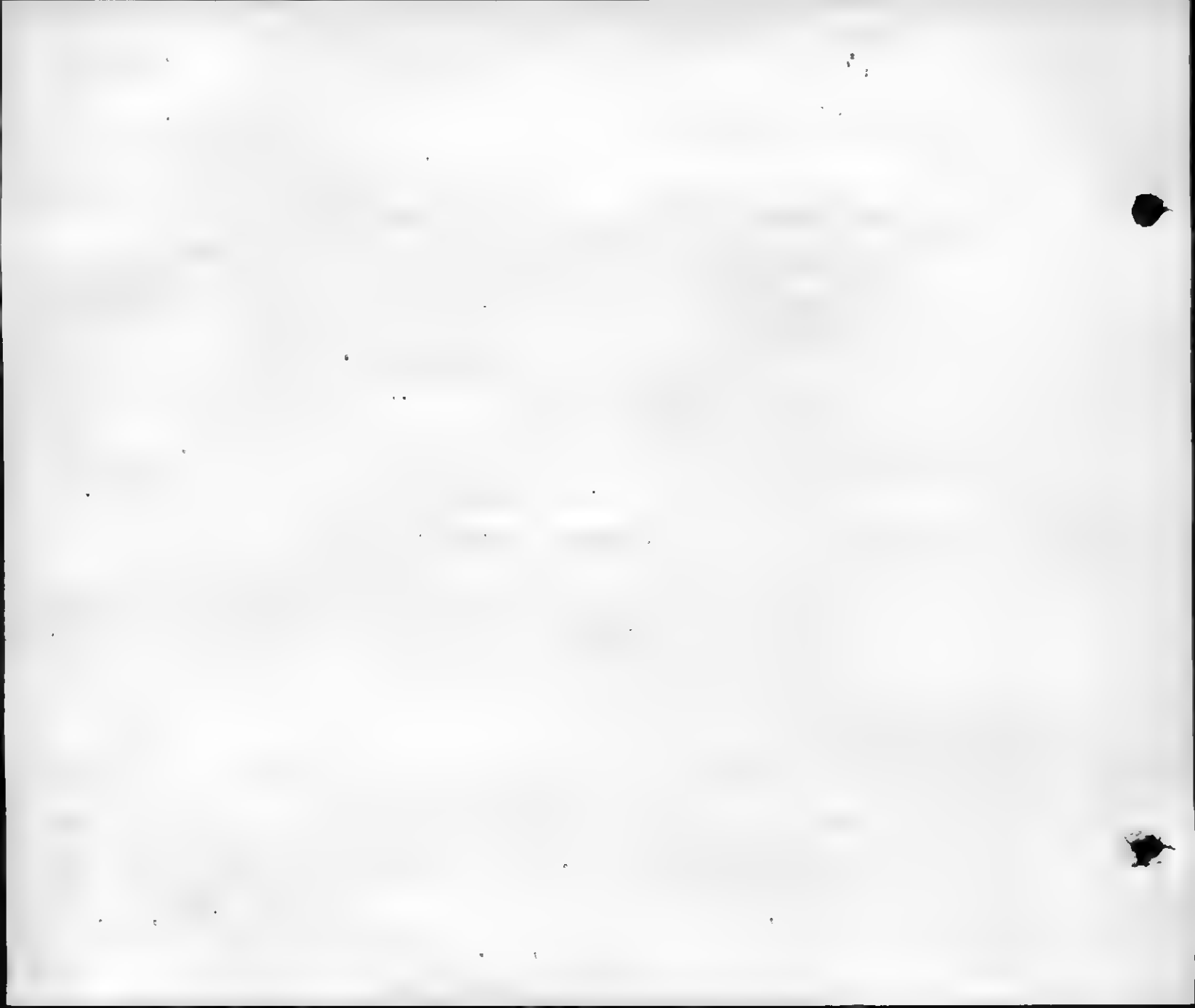
05837

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>OLNEY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>TRIDELPHIA ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EFFIE</b> Middle <b>LAVERNA</b> Last <b>REED</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>21</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/24/06</b>		9. AGE (In years lost birthday) <b>54</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>DAVID COOK</b>				14. MOTHER'S MAIDEN NAME <b>GERTIE FRAZIER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>XXXXXXXXXXXXXXXXXXXX</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 DAYS</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): <b>RHEUMATIC ENDOCARDITIS (MITRAL STENOSIS)</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/27/1961</b> to <b>MAY 21, 1961</b> that (I) (we) last saw the deceased alive on <b>MAY 20, 1961</b> , and that death occurred at <b>A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Charles S. Whitaker</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>5/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M. D.</b>				22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 23, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sharon Baptist</b>		23d. LOCATION (City, town, or county) (State) <b>West Friendship, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. McLaughlin</b>				ADDRESS <b>Damascus, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 24 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Howard</b>			

may be filed by the hospital or attending physician  
TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)  
ISM 9/59

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5853

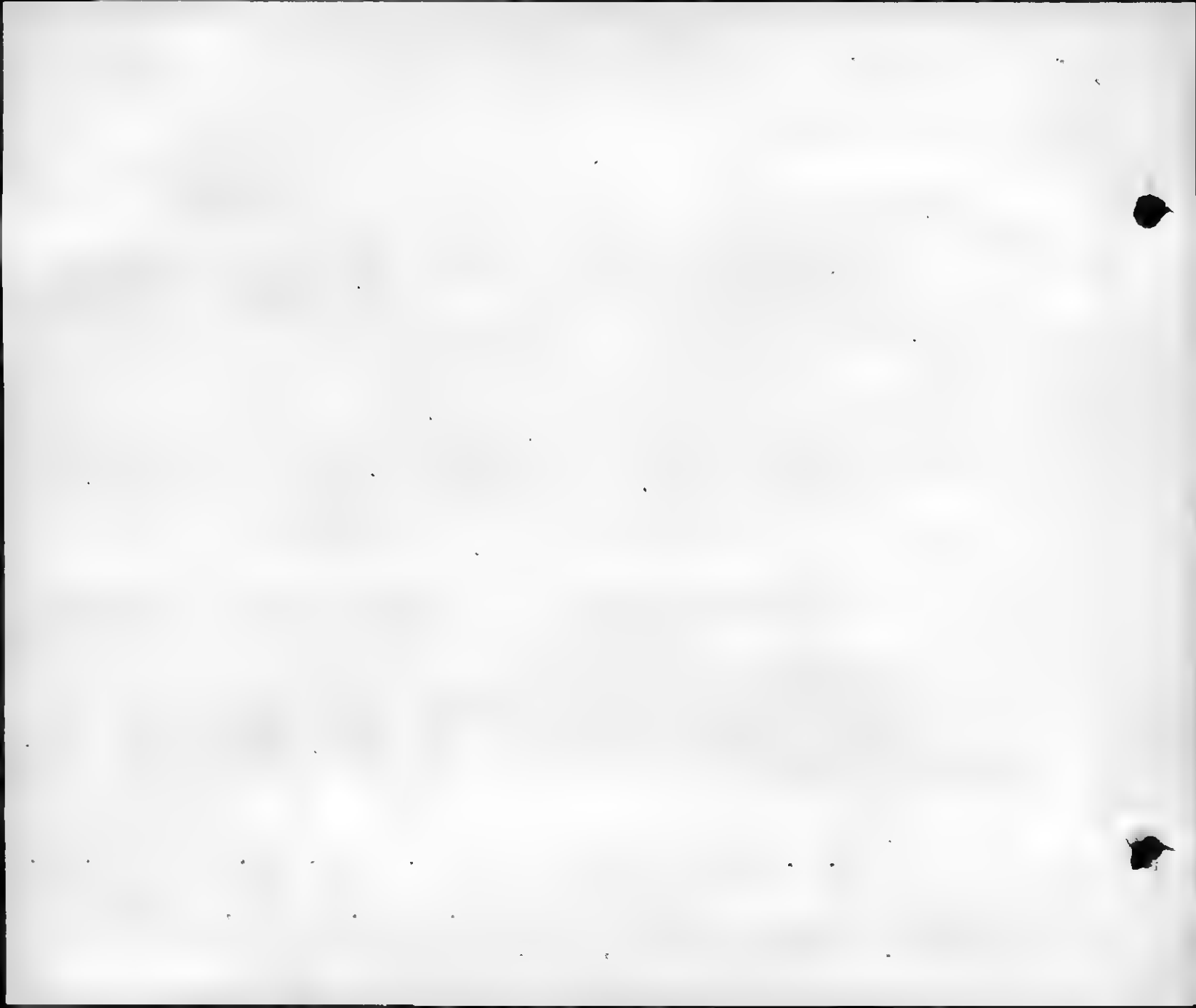
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05840

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Syrs</i> c. LENGTH OF STAY IN 1b <i>5 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Alta Vista Nursing Home</i>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write, RURAL and give nearest town) <i>Rockville</i> d. STREET ADDRESS <i>4219 Roundhill Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>Virginia</i> Middle <i>Alice</i> Last <i>Reedy</i>		4. DATE OF DEATH Month <i>May</i> Day <i>10</i> Year <i>1961</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>June 10 1877</i>
9 AGE (In years last b. day) <i>83</i> yrs		10 IF UNDER 1 YEAR Months <i>11</i> Days <i>0</i> Hours <i></i> Min <i></i>	11 IF UNDER 24 HRS Hours <i></i> Min <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H.W.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16 SOCIAL SECURITY NO <i>None</i>	
17 INFORMANT <i>Nursing Home Records</i>		Address <i></i>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Trauma</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>20 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State) <i></i>
21 I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>10 May 1961</i> that (I) (we) last saw the deceased alive on <i>1961</i> and that death occurred at <i>10 May 1961</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Wm. S. Murphy</i>		22b. DATE SIGNED <i>10 May 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Wm. S. Murphy</i>		22d. ADDRESS <i>615 W. Montg. Ave. Rockville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>5/13/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant View Cem.</i>	23d. LOCATION (City, town, or county) (State) <i>Mt. Jackson, Virginia</i>
24 FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		25a. REC'D BY REGISTRAR DATE <i>MAY 15 '61</i>	
ADDRESS <i>Bethesda, Maryland</i>		25b. REGISTRAR'S SIGNATURE <i>Clifford S. Hanna</i>	





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1



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5854

Item 14 Film G287 5/17/61 mh

05841

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bethesda

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Suburban

### 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

b. COUNTY

D.C.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

d. STREET ADDRESS

3891-Porter Rd NW

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

### 3. NAME OF DECEASED

(Type or print)

Ethel M. Reese

### 5. SEX

female

### 6. COLOR OR RACE

white

### 7. MARRIED

☐ NEVER MARRIED

### 8. DATE OF BIRTH

11/19/07

### 9. AGE (In years, last birthday)

53 yrs.

### 10. IF UNDER 1 YEAR

Months

Days

### 11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Free Secretary Dept. of State

11. BIRTHPLACE (County & State, or foreign country)

Middletown Ohio

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

### 13. FATHER'S NAME

John W. Besswee

### 14. MOTHER'S MAIDEN NAME

Unknown

### 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give year or dates of service)

NO

### 16. SOCIAL SECURITY NO.

(SON) John Reese

5054

Address Rm. Lane

### 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

Congestive Heart Failure  
Myocarditis

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

20d. INJURY OCCURRED While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 19 to May 8, 1961, that (I) (we) last saw the deceased alive on 19, and that death occurred at 9:20 P.M. from the causes and on the date stated above.

### 22a. SIGNATURE

De Witt E. DeLawter

M.D.

ATTENDING PHYS

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

5/8/61

### 22c. PHYSICIAN'S NAME (Type)

DEWITT E. DELAWTER

### 22d. ADDRESS

8025 ABERDEEN Rd. Bethesda 14, Md.

### 23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial-transit 5-9-61

### 23c. NAME OF CEMETERY OR CREMATORY

Woodside Cemetery

### 23d. LOCATION (City, town or county)

Middletown, Ohio

### 24. FUNERAL DIRECTOR'S SIGNATURE

ROBERT A. PUMPHREY

### ADDRESS

Bethesda, Md.

### 25a. REC'D BY REGISTRAR

DATE MAY 11 '61

### 25b. REGISTRAR'S SIGNATURE

Arthur S. Hines

VR A15 (4)  
15M 9/60

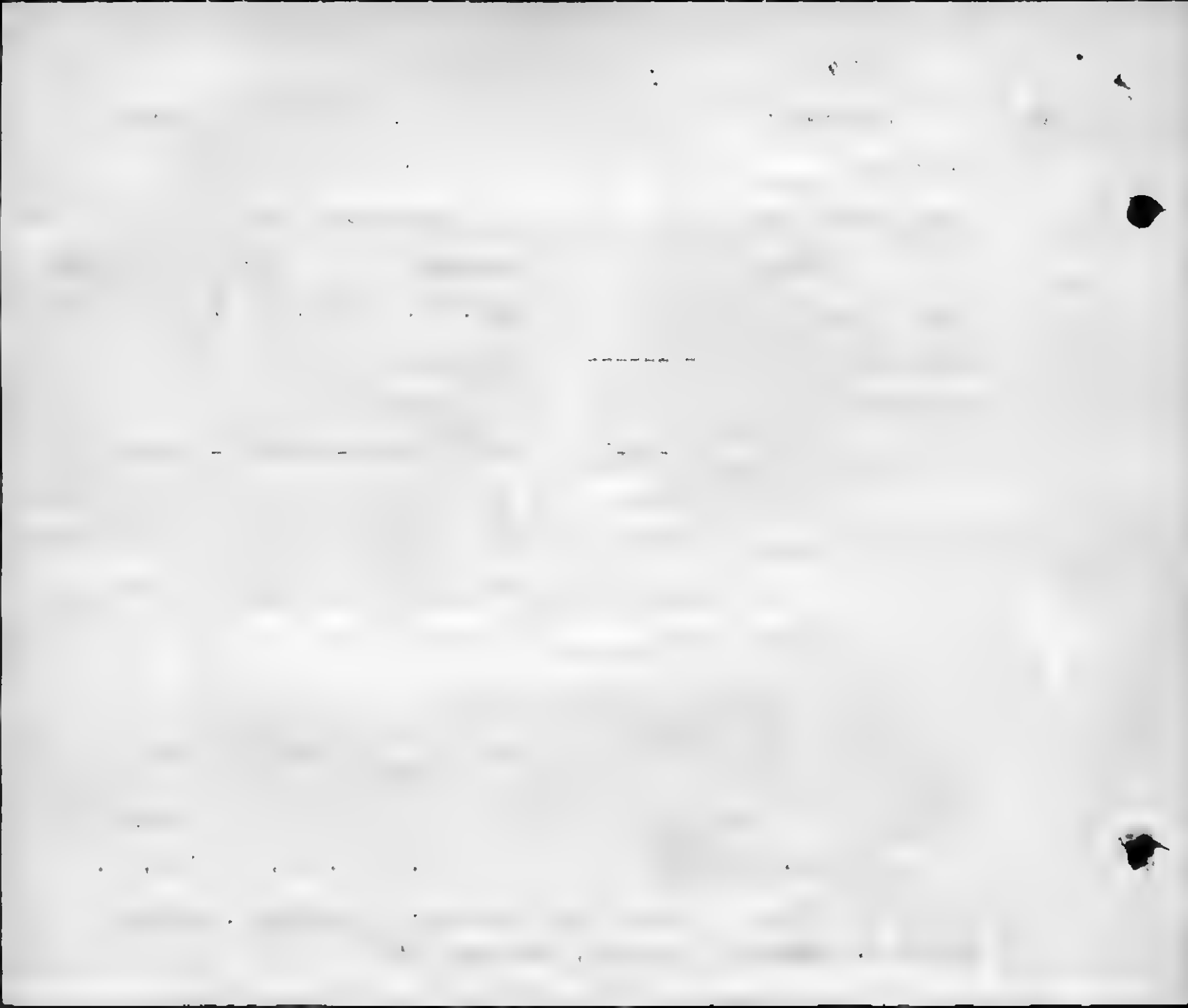


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VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5855 Items 8, 9 & 12 film copy 778761-112  
05842  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>1302 Abbot Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Walla</b>		4. DATE OF DEATH <b>May 10 1961</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 29, 1889</b>		9. AGE (in years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b>		11. IF UNDER 24 HRS. Hours <b>7</b> Min. <b>11</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sweden</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sweden</b>		12. CIT <b>Sweden</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>127-14-1333</b>		17. INFORMANT <b>Gloria Fleming-Daughter-Same 2d</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RENAL FAILURE</b> DUE TO (c) <b>CARCINOMA OF GALLBLADDER</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>GENERALIZED METASTASIS</b>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Rockville</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 26, 1961</b> to <b>MAY 11, 1961</b> , that (I) (we) last saw the deceased alive on <b>MAY 10, 1961</b> , and that death occurred on <b>MAY 10, 1961</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Gordon S. Rosenberger</b>		22b. DATE SIGNED <b>MAY 10, 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>		22d. ADDRESS <b>310 W. Montg. Ave, Rockville, Md.</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <b>310 W. Montg. Ave, Rockville, Md.</b>		22g. DATE <b>MAY 15 '61</b>		22h. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>		22i. REGISTRAR'S NAME <b>Arthur S. Hous</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>5/15/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) <b>Suitland, Maryland</b>		23e. STATE <b>Md.</b>		23f. ADDRESS <b>Bethesda, Maryland</b>		23g. DATE <b>MAY 15 '61</b>		23h. REGISTRAR'S SIGNATURE <b>Arthur S. Hous</b>		23i. REGISTRAR'S NAME <b>Arthur S. Hous</b>		23j. REGISTRAR'S ADDRESS <b>Bethesda, Maryland</b>	



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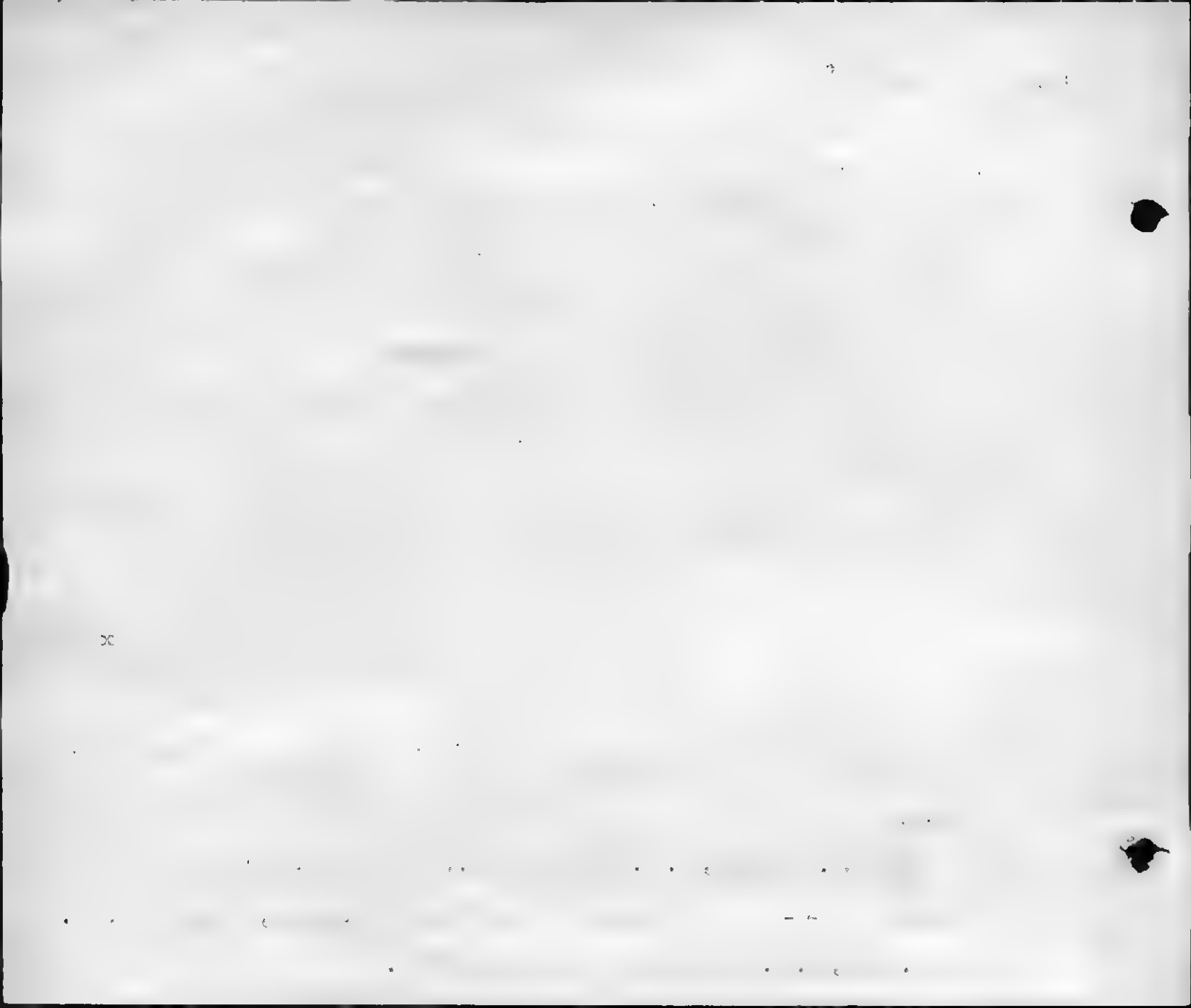
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VR A15 (4)  
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
5856-05843															
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN <u>16 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LANGLEY PARK</u> d. STREET ADDRESS <u>7914 14<sup>th</sup> ST.</u>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>REID</u>				4. DATE OF DEATH Month Day Year <u>MAY 9 1961</u>				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>							
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>MAY 8, 1961</u>				9. AGE (In years last birthday) <u>16</u> 10. IF UNDER 1 YEAR Months Days <u>16</u> 11. IF UNDER 24 HRS. Hours Min. <u>30</u>				12. CITIZEN OF WHAT COUNTRY?							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Stephen Sidney Reid</u>				14. MOTHER'S MAIDEN NAME <u>MARILYN JANET WHITMORE</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Stephen Reid</u>				17. INFORMANT Address <u>7914 14<sup>th</sup> ST.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ATELECTASIS</u> 782.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>PREMATURITY</u> 19. WAS AUTOPERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20d. City or town (County) (State)															
21. I certify that (I) ( <u>in hospital</u> ) attended the deceased from <u>5-8, 1961</u> , to <u>5-9, 1961</u> , that (I) ( <u>no</u> ) last saw the deceased alive on... <u>19</u> , and that death occurred at... <u>5-9-61</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>MARY K. L. Sartwell</u> 22c. PHYSICIAN'S NAME (Type) <u>Mary K.L. Sartwell, M. D. 6811 Riggs Rd., Hyattsville, Maryland</u>				22b. DATE SIGNED <u>5-9-61</u>				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>5-9-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u> 23d. LOCATION (City, town or county) (State)															
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M. D. Washington Sanitarium and Hosp.</u>				25a. REC'D BY REGISTRAR <u>MAY 10 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

5857

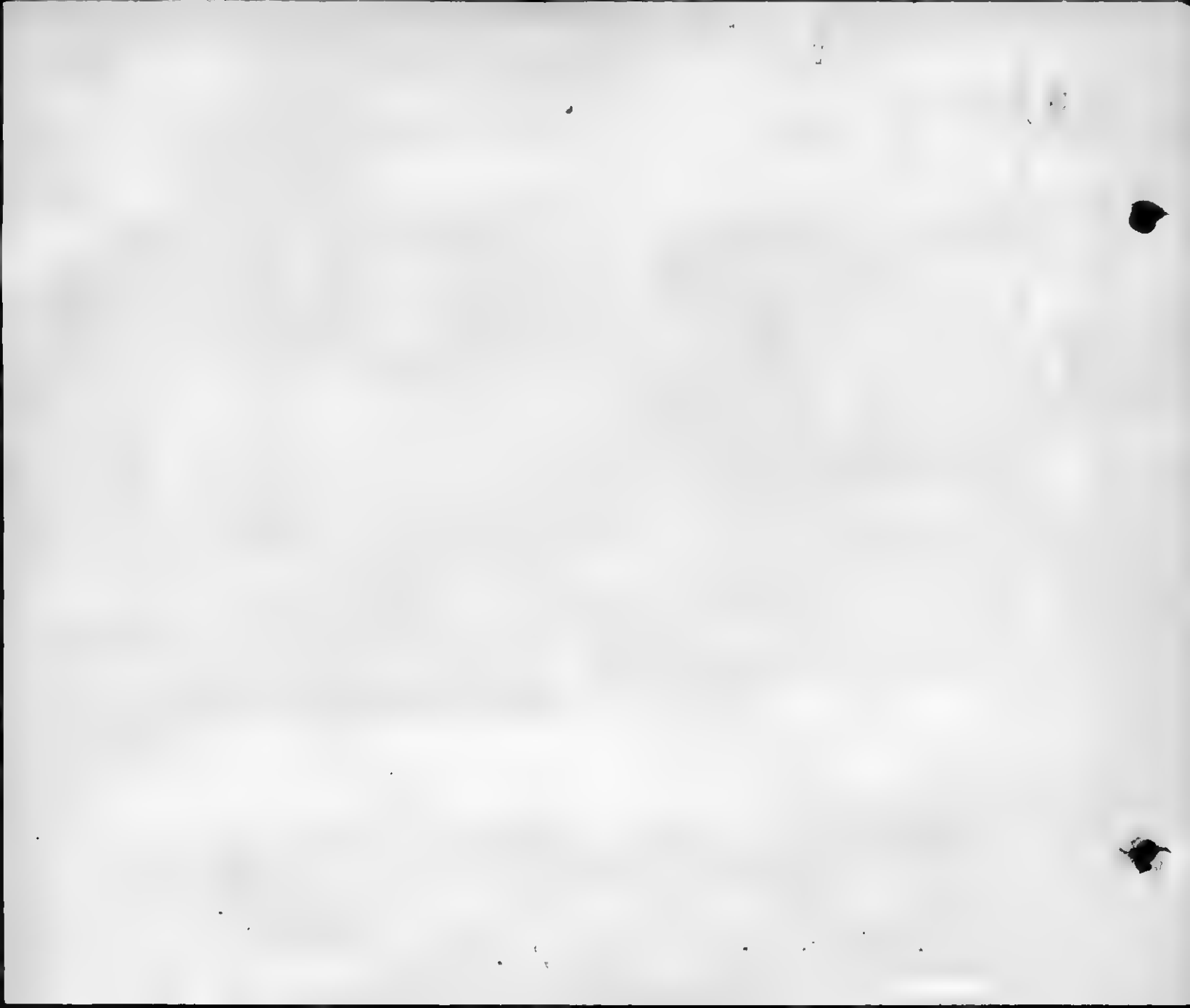
5857

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05844

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11600 Orebaugh Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY IRVING REININGA</u>		4. DATE OF DEATH <u>May 9 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1842</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry Queen</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>
13. FATHER'S NAME <u>HARRY REININGA</u>		14. MOTHER'S MAIDEN NAME <u>Jane James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Army WW2</u>		16. SOCIAL SECURITY NO. <u>351-25-7180</u>	
17. INFORMANT <u>Hospital Records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>162.1</u> DUE TO <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>162.1</u> DUE TO <u>162.1</u> (c) <u>162.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 61</u> to <u>May 8 1961</u> , that (I) (we) last saw the deceased alive on <u>May 8 1961</u> , and that death occurred <u>3:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>George William Ware</u>		22b. DATE SIGNED <u>5/9/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George William Ware</u>		22d. ADDRESS <u>1835 Eye St NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>5/12/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate Of Heaven</u>	23d. LOCATION (City, town or county) (State) <u>Montgomery Co. Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR <u>MAY 15 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>		25c. ADDRESS <u>8434 Georgia Ave, Silver Spring, Md.</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

5858

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

45845

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY (in days) <b>39 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Berkley Springs</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Berkley Springs</b> d. STREET ADDRESS <b>8282</b>	
3. NAME OF (Type or print) <b>Harold Alston RICE</b>		4. DATE OF DEATH <b>May 25 1961</b>	
5. SEX <b>Male</b>		6. CO. OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-94</b>	
9. AGE (in years, last birthday) <b>66 yrs.</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>25</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Educational Adviser</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ICA</b>	
11. BIRTHPLACE (County & State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank RICE</b>		14. MOTHER'S MAIDEN NAME <b>Bertha FISHER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>(W) Mrs. Eleanor Rice, same as #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aneurysm (ascending aorta) with rupture into left lung</b> DUE TO (b) <b>History undetermined (One day postoperative)</b> DUE TO (c) <b>History undetermined (One day postoperative)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <b>Interval between onset and death</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 16, 1961</b> , to <b>May 25, 1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 25, 1961</b> , and that death occurred at <b>10A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>James E. Mc Clenathan</b>		22b. DATE SIGNED <b>5-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>James E. MC CLENATHAN, CDR, MSC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-29-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenway Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Berkley Springs W. Va.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>MAY 29 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-100. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5859 05846

1. PLACE OF DEATH  
 a. COUNTY Montgomery MARYLAND  
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring  
 c. LENGTH OF STAY IN IN D.O.A.  
 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 901 Bessing Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  
 a. STATE D.C. b. COUNTY Montgomery  
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington  
 d. STREET ADDRESS 612 N ST., N.W.

3. NAME OF DECEASED (Type or print) Frank Richardson  
 4. DATE OF DEATH May 9 1961  
 5. SEX male 6. COLOR OR RACE col 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 12-22-10 9. AGE (in years last birthday) 50 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed 10b. KIND OF BUSINESS OR INDUSTRY Wa 11. BIRTHPLACE (State or foreign country) Va 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Timothy Richardson 14. MOTHER'S MAIDEN NAME Mandy unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and date of service) M.C. Police 16. SOCIAL SECURITY NO. 17. INFORMANT M.C. Police Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
 PART I. DEATH WAS CAUSED BY:  
 IMMEDIATE CAUSE (a) Friedlander's Pneumonia  
 491X DUE TO  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)  
 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  
 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  
 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 3 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant M.D. CHIEF MEDICAL EXAMINER ☐  
 EXAMINER'S NAME (Type) FRANK J. Broschant ASSISTANT MEDICAL EXAMINER ☐  
 DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 5-9-61  
 Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 5/13/61 22c. NAME OF CEMETERY OR CREMATORY County Home 22d. LOCATION (City, town, or country) (State) Rockville, Md.

23. FUNERAL DIRECTOR Robert L. Snowden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR MAY 15 '61 24b. REGISTRAR'S SIGNATURE Charles L. Evans



**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5860		05847	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>	c. LENGTH OF STAY IN to <b>6 DAYS</b>	X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAYTONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>		e. STREET ADDRESS <b>1</b>	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCIS GUY RIORDAN</b>		4. DATE OF DEATH Month Day Year <b>MAY 12, 19 61</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1-21-1893</b>
9. AGE (In years lost birthday) <b>68 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD RIORDAN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BRIGHTWELL</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <b>yes WW1 217 32 1739</b>		16. SOCIAL SECURITY NO. <b>217 32 1739</b>	
17. INFORMANT <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra-Cranial Hemorrhage</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost (c) _____ DUE TO (b) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5-6</b> <b>1961</b> to <b>5-12</b> <b>1961</b> , that (I) (we) lost saw the deceased alive on <b>5-11</b> <b>1961</b> , and that death occurred at <b>2 30</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b>		22b. DATE SIGNED <b>5-12-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5-15-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b>	23d. LOCATION (City, town, or county) (State) <b>Libertytown, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>Laytonville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>		DATE <b>MAY 15 '61</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

05848

5861

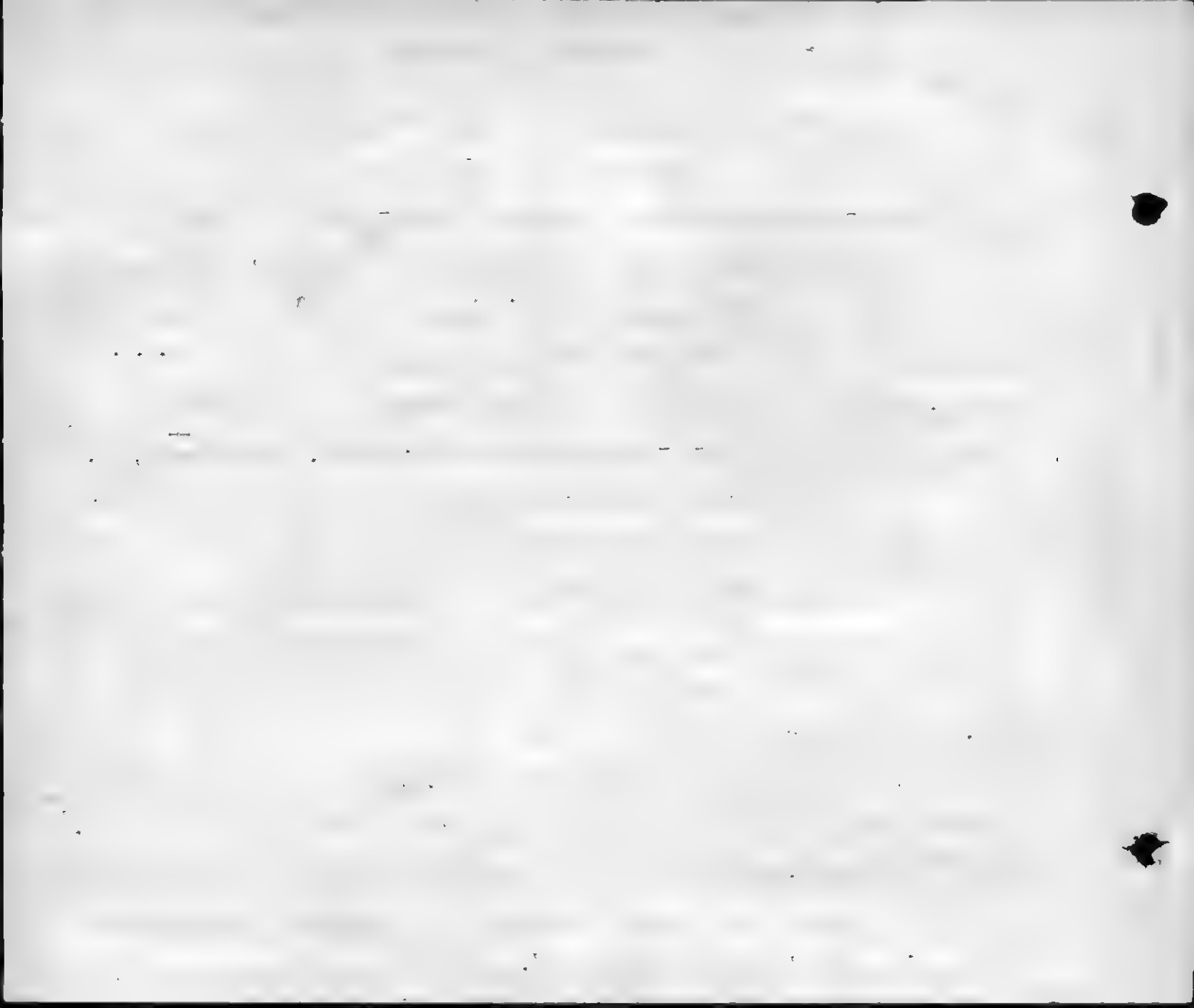
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Five years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>170 Glenmont - Colesville Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles Edgar Robey</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> , Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1 872</b>
9. AGE (In years last birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b></b> Min <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Druggist</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Robey</b>		14. MOTHER'S MAIDEN NAME <b>Alexenia Roby</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-07-1328</b>	
17. INFORMANT <b>Miss Lucille C. Robey</b>		Address <b>170 Glenmont - Colesville Rd. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Urinary Tract infection</b> DUE TO (b) <b>Amputation Left leg</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>2 months</b> <b>20 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>4.00</b> a.m. <b>5/16/61</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January</b> , 19 <b>61</b> , to <b>5/16/61</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/13/61</b> , 19 <b>61</b> , and that death occurred at <b>4.00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8107 Eastern Avenue Silver Spring, Md.</b> DATE SIGNED <b>May 16, 1961</b> ACTUAL SIGNATURE <b>Bernard H. Ostrow</b> FURNITURER'S NAME (Type) <b>Bernard H. Ostrow</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/18/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery County Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey, Inc</b> <b>Raymond A. Zaka</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 22 '61</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death: Page 4

may be required by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

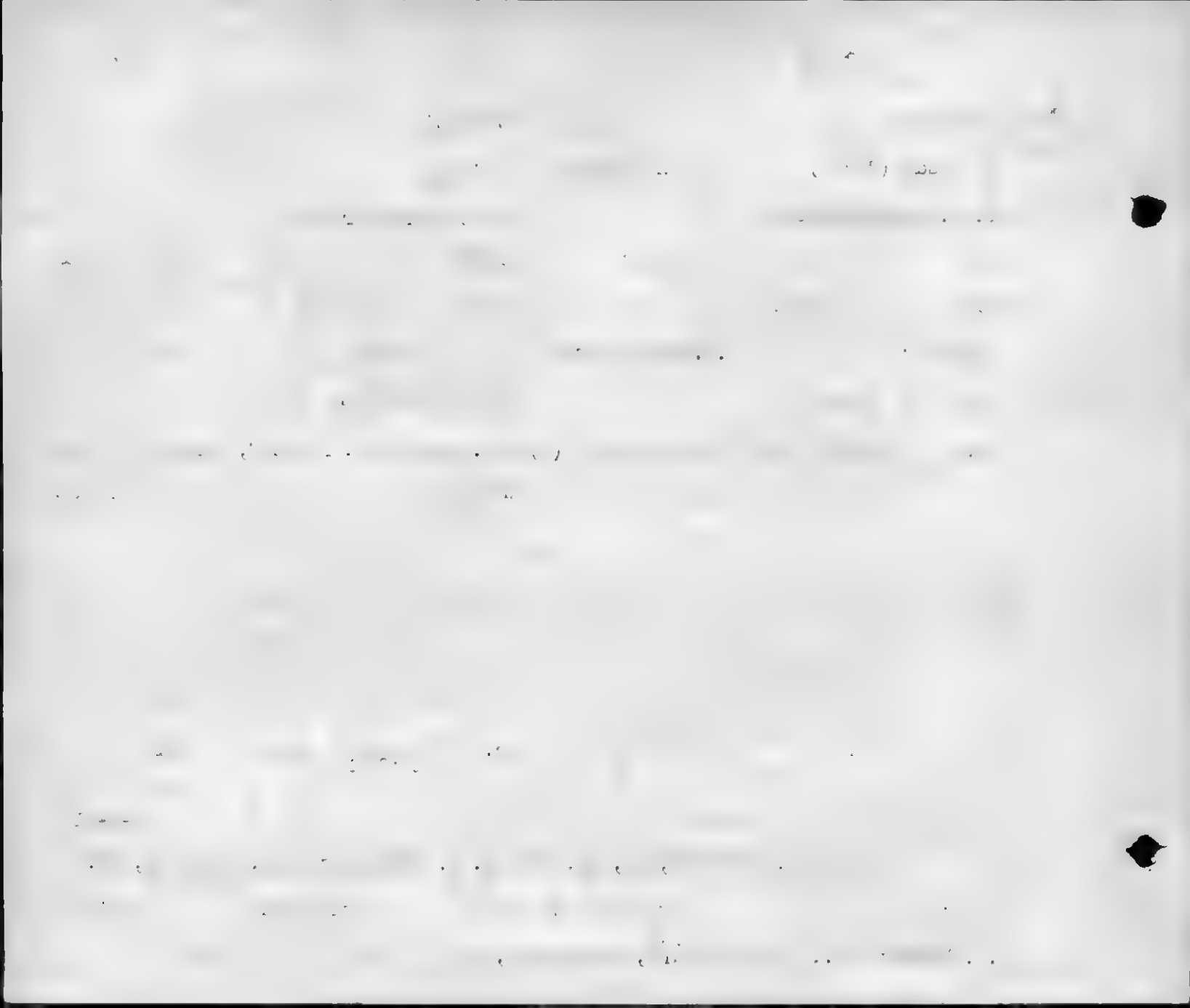
## CERTIFICATE OF DEATH

5862

05849

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY in 1b <b>132 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Triangle</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>25 Courtney Drive</b>		d. STREET ADDRESS <b>May 3 1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Carl Albert ROHLOFF</b>		4. DATE OF DEATH <b>May 3 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>7-10-34</b>		9. AGE (in years last birthday) <b>26</b> yrs.		10. UNDER 1 YEAR Months <b>5</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps</b>		11. BIRTH PLACE (Country & State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry B. ROHLOFF</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mae PURCELL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>1956 to 1961</b>							
17. INFORMANT <b>(W) Mrs. Marilyn A. Rohloff, same as # 2 above</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, acute, monocytic</b> DUE TO (b) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 months</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Dec. 22 1960 to May 3 1961</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18) <b>12:35 PM</b>		20c. TIME OF INJURY Month, Day, Year <b>19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Arlington National</b>		20f. (City or town) <b>Arlington</b>		20g. (County) <b>Virginia</b>		20h. (State) <b>Virginia</b>	
21. I certify that (X) (this hospital) attended the deceased from <b>Dec. 22 1960</b> to <b>May 3 1961</b> , that (X) (we) last saw the deceased alive on <b>May 3 1961</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Joseph E. Stitcher</b>		22b. DATE SIGNED <b>5-3-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Joseph E. STITCHER, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) <b>Arlington</b>		23e. (State) <b>Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co., 3072 M St., NW, Washington, DC</b>		25a. REC'D BY REGISTRAR <b>MAY 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. DATE <b>MAY 5 '61</b>		25d. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25e. DATE <b>MAY 5 '61</b>		25f. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25g. DATE <b>MAY 5 '61</b>		25h. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25i. DATE <b>MAY 5 '61</b>			

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15M 9/60



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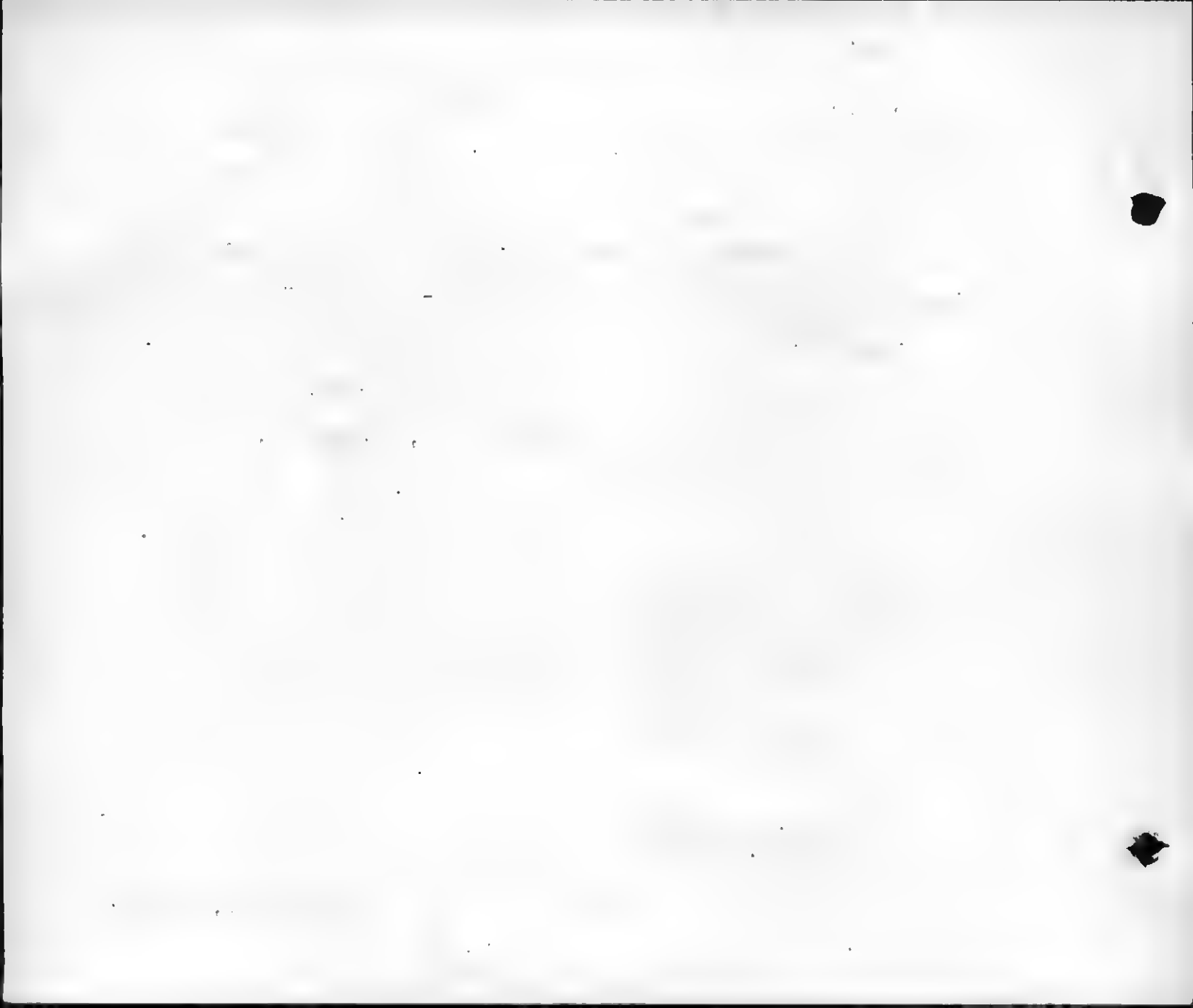
## CERTIFICATE OF DEATH

Reg. Dist. No 05850

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Giles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>		c. LENGTH OF STAY IN 1b <b>7 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>X-1</b>	
3 NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Payne</b> Last <b>Ross</b>		4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22-1911</b>
9. AGE (In years last birthday) <b>50</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>	
13. FATHER'S NAME <b>James Hewitt</b>		14. MOTHER'S MAIDEN NAME <b>Martha Sarver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Albert Ross, Barnesville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>120.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease (Atherosclerosis)</b> (c) <b>Hypertensive-Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>8 months</b> <b>2 years</b>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 May</b> , 19 <b>59</b> , to <b>23 May</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>23 May</b> , 19 <b>61</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gordon M. Smith</b>		DATE SIGNED <b>23 May 61</b>	
PHYSICIAN'S NAME (Type) <b>Gordon M. Smith</b>		ADDRESS (Street, city or town, state) <b>Barnesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/26/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Hunt</b>	
ADDRESS <b>Barnesville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 31 '61</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event with n 72 hours after death.



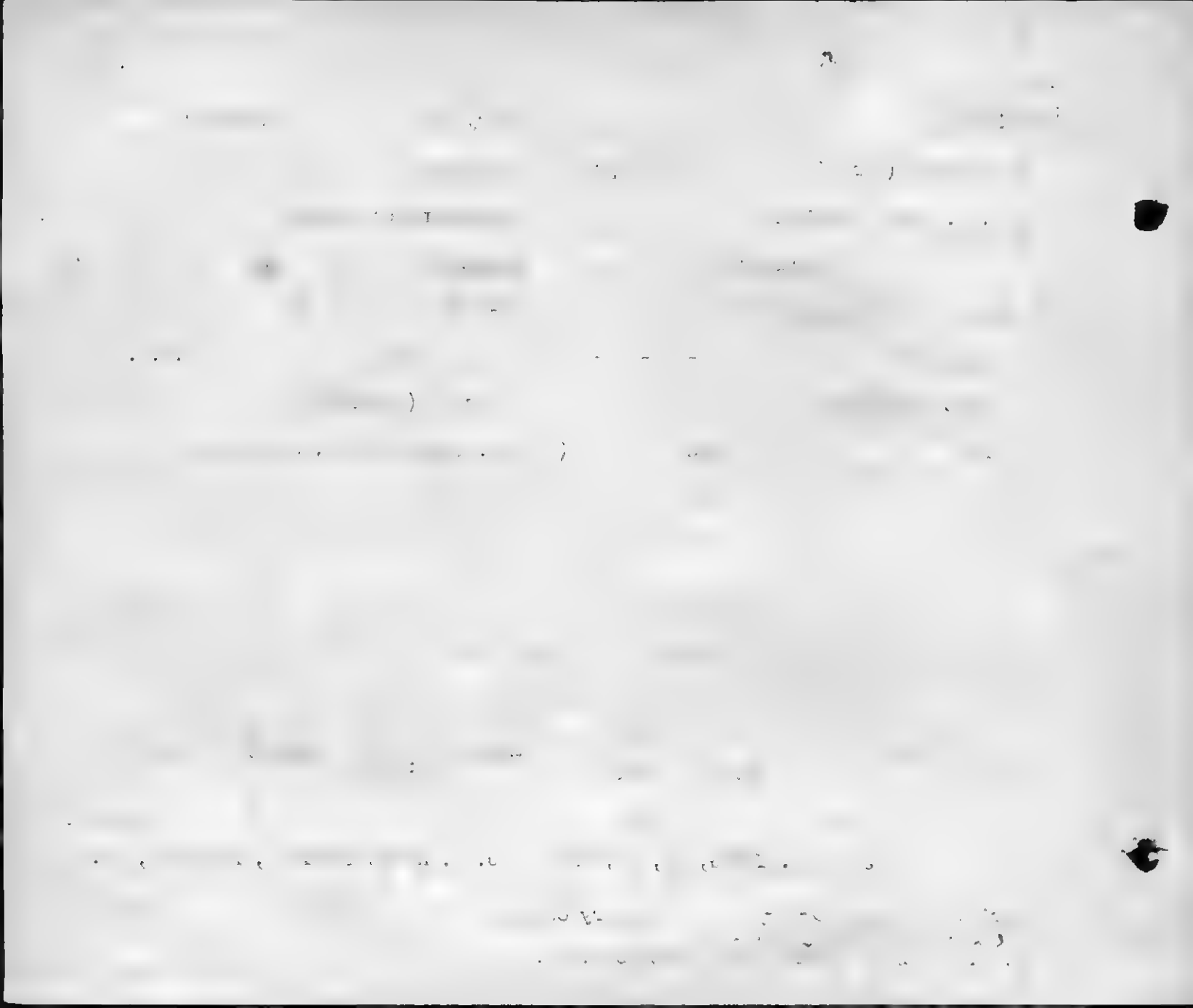
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				
c. LENGTH OF STAY IN b. <b>10 days</b>					d. STREET ADDRESS <b>9809 Montauk Avenue</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Frances</b>					4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 61</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>Caucasian</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>11-7-86</b>				
9. AGE (In years, last birthday) <b>74</b> yrs.					10. IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b>				
11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>61</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Martin ROZNOSKI</b>					14. MOTHER'S MAIDEN NAME <b>Katherine (unknown)</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>(D) Mrs. Laverne Koon, same as #2 above</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Malignant Teratoma</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>3 weeks</b> <b>3 years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 years</b>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 15</b> <b>1961</b> to <b>May 25</b> <b>1961</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 25</b> <b>1961</b> , and that death occurred at <b>6:08AM</b> , from the causes and on the date stated above.					22a. SIGNATURE <b>James M. Young, LT, MC, USN</b>				
22b. DATE SIGNED <b>5-25-61</b>					22c. PHYSICIAN'S NAME (Type) <b>James M. Young, LT, MC, USN</b>				
22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>					23b. DATE THEREOF <b>5-26-61</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>					23d. LOCATION (City, town or county) (State) <b>Toledo Ohio</b>				
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>					25a. REC'D BY REGISTRAR <b>MAY 29 '61</b>				
25b. REGISTRAR'S SIGNATURE <b>Lawrence S. Hines</b>					25c. REGISTRAR'S NAME <b>Lawrence S. Hines</b>				



5865

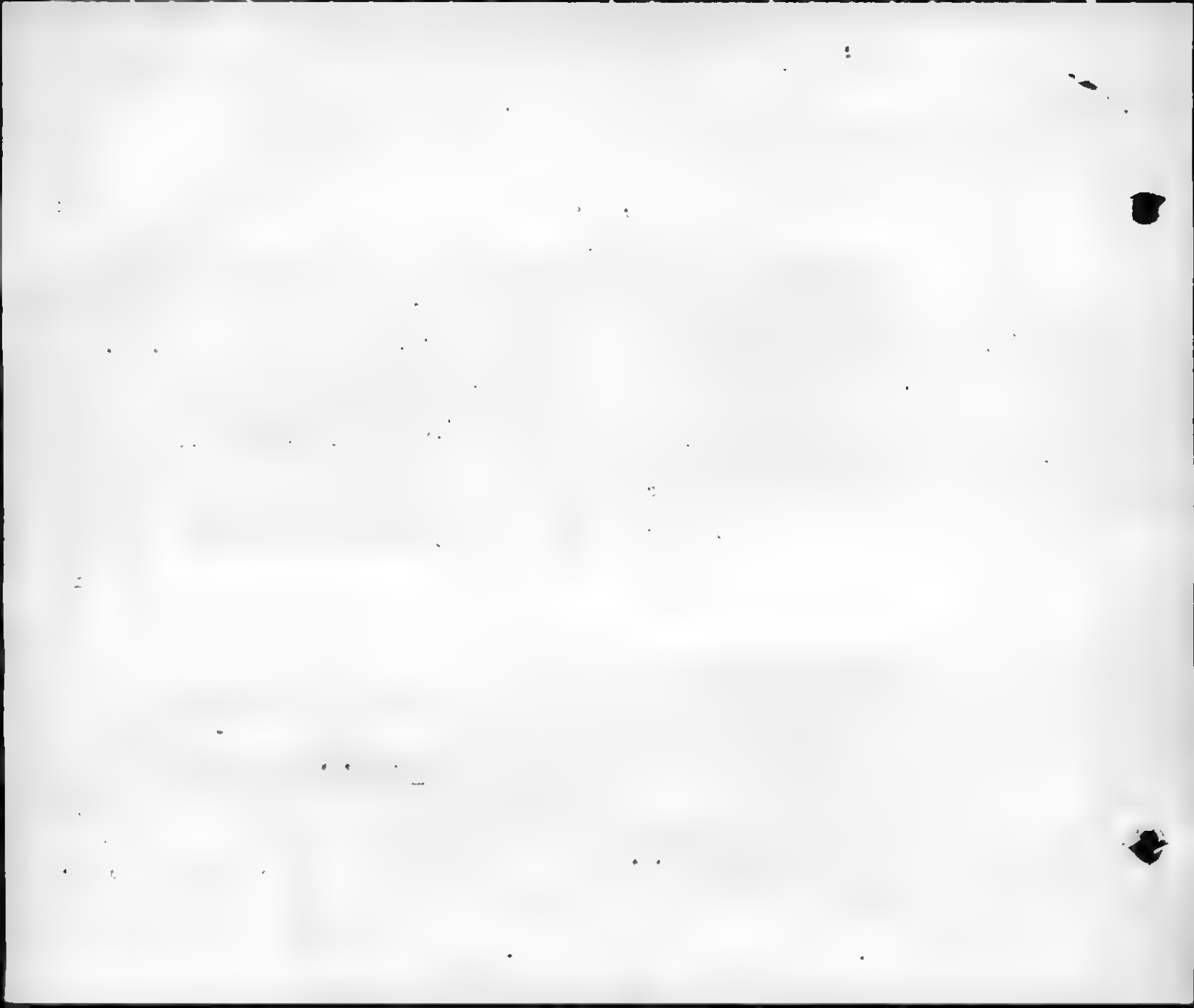
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05852

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		d. STREET ADDRESS <b>3854 North Second Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Emmerson</b> Last <b>Runion</b>		4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1961</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1954</b>
9 AGE (In years last birthday) <b>6</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b> Hours <b>16</b> Min <b>16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Owen Runion</b>		14. MOTHER'S MAIDEN NAME <b>Avis Funkhouser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Congenital Heart Disease, Tetralogy of Fallot</b> DUE TO (c) <b>Corrective cardiac surgery</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b> <b>6 hours</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 14, 1961</b> to <b>May 16, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 16, 1961</b> , and that death occurred at <b>6:30 p.m.</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Alan Goldblatt</i>		22b. DATE <b>5/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ALLAN GOLDBLATT, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-transit 5-17-61</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Faulks Run, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>		DATE <b>MAY 23 '61</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

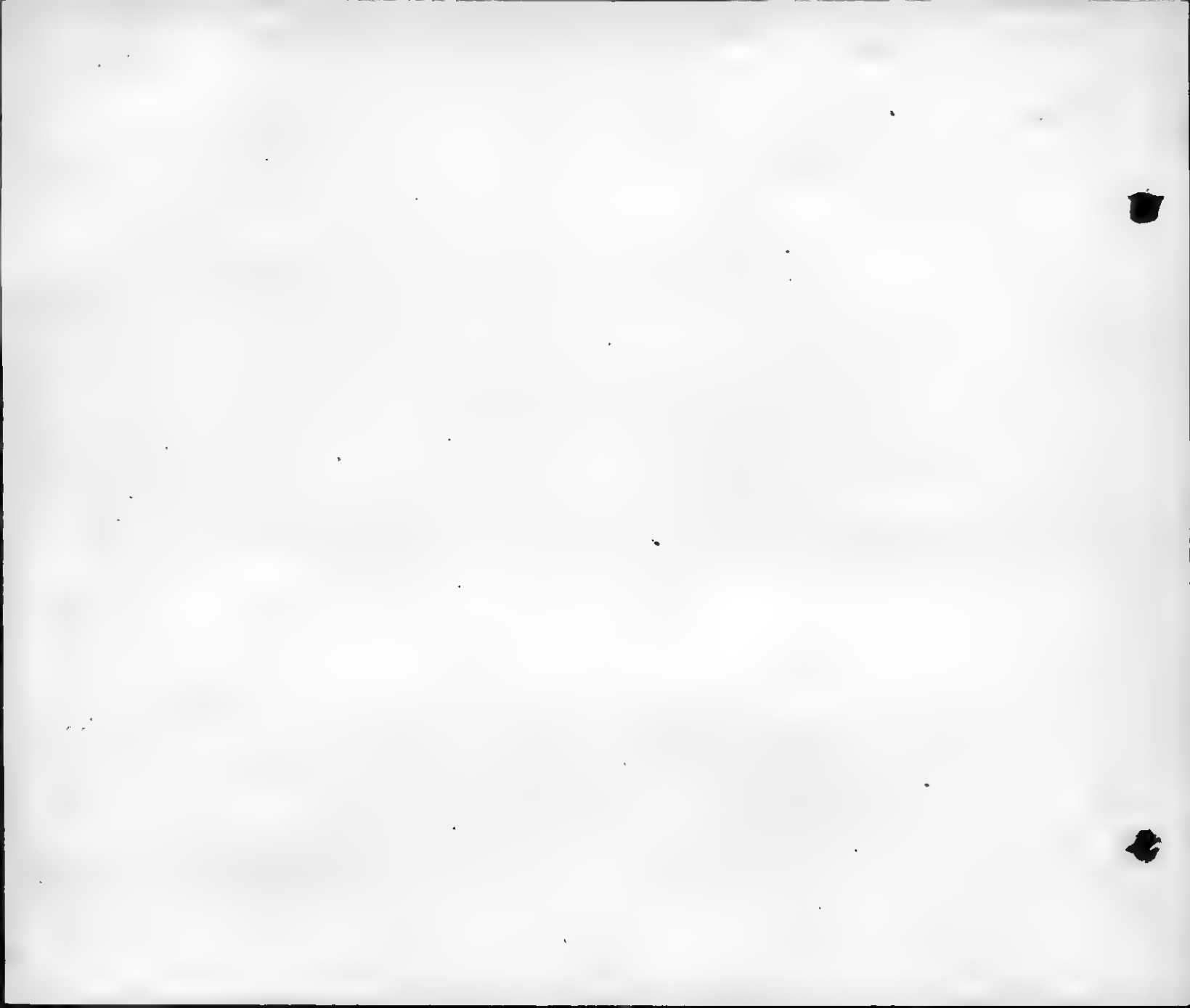
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5866

05853

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Montgomery</i> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		d. STREET ADDRESS <i>7111 Carroll Avenue</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7111 Carroll Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <i>SEMU</i> First <i>SATO</i> Last				<b>4. DATE OF DEATH</b> Month <i>5</i> Day <i>11</i> Year <i>1961</i>			
<b>5. SEX</b> <i>Female</i>		<b>6. COLOR OR RACE</b> <i>Oriental</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>Sept. 19, 1880</i>	
<b>9. AGE</b> (In years last birthday) <i>80</i> yrs		<b>10. IF UNDER 1 YEAR</b> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		<b>11. IF UNDER 24 HRS</b> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>Japan</i> ✓	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>at home</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Japan</i>	
<b>13. FATHER'S NAME</b> <i>Yamauchi</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Not Available</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i> (If yes, give war(s)/dates of service)				<b>16. SOCIAL SECURITY NO</b> <i>7409 Hollyline Jct Pk Md</i>			
<b>17. INFORMANT</b> <i>Mrs. Florence Nishimoto</i> Address <i>7409 Hollyline Jct Pk Md</i>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO (b) <i>Congestive failure &amp; hypertension</i> DUE TO (c) <i>Cerebrovascular accident</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <i>19</i> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)				<b>20g. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>May 1953</i> <b>to</b> <i>May 1961</i> <b>that (I) (we) last saw the deceased alive on</b> <i>5-11-61</i> <b>and that death occurred</b> <i>6:25 P.M.</i> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>Ernest A. Sarao</i>				<b>22b. DATE SIGNED</b> <i>5/11/61</i>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <i>ERNEST A. SARAO</i>				<b>22d. ADDRESS</b> <i>7006 New Hampshire Ave Jct Pk Md</i>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Cremation</i>		<b>23b. DATE THEREOF</b> <i>May 13, 1961</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Mid Western Crematory</i>		<b>23d. LOCATION (City, town, or county)</b> (State) <i>Prince Georges County, Md.</i>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Arthur H. Harts</i>				<b>25a. REC'D BY REGISTRAR</b> <i>MAY 15 '61</i>			
<b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Harts</i>				<b>25c. REGISTRAR'S SIGNATURE</b>			



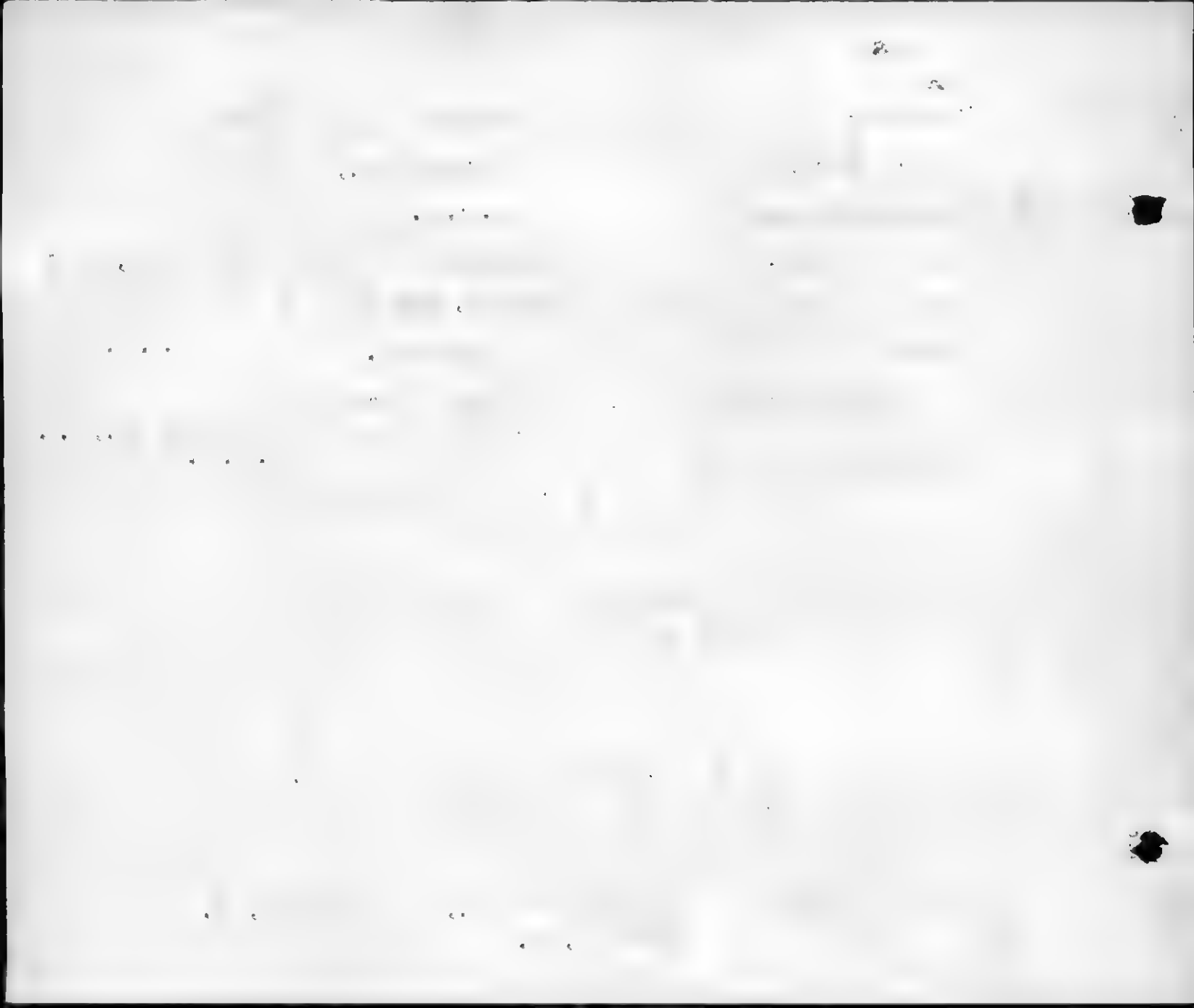
may be required by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5867

05854

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Norbeck (Rural)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bradford Rest Home</b>				e. STREET ADDRESS <b>Gaithersburg, Md. R. F. D. # 2</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CARRIE SATTERFIELD</b>				4. DATE OF DEATH Month Day Year <b>May 21, 1961</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23, 1889</b>		9. AGE (In years lost birthday) <b>71</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Mm
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME <b>Lawrence Braxton</b>				14. MOTHER'S MAIDEN NAME <b>Barry Luckett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Hazel Kennedy 2001 Maryland Ave., N. E. Wash. D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma generalized</b> <b>Breast Cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>17 yrs.</b> (c) <b>17 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension C.R.D.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 30, 1960</b> to <b>May 21, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 20, 1961</b> , and that death occurred at <b>1:12 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert L. Snowden</b>				22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. ADDRESS <b>Rockville, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>5/25/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National.</b>	
23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>				23e. REC'D BY REGISTRAR DATE <b>MAY 23 '61</b>		23f. REGISTRAR'S SIGNATURE	



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Item 14 11.11.61 2.13.61 jwk

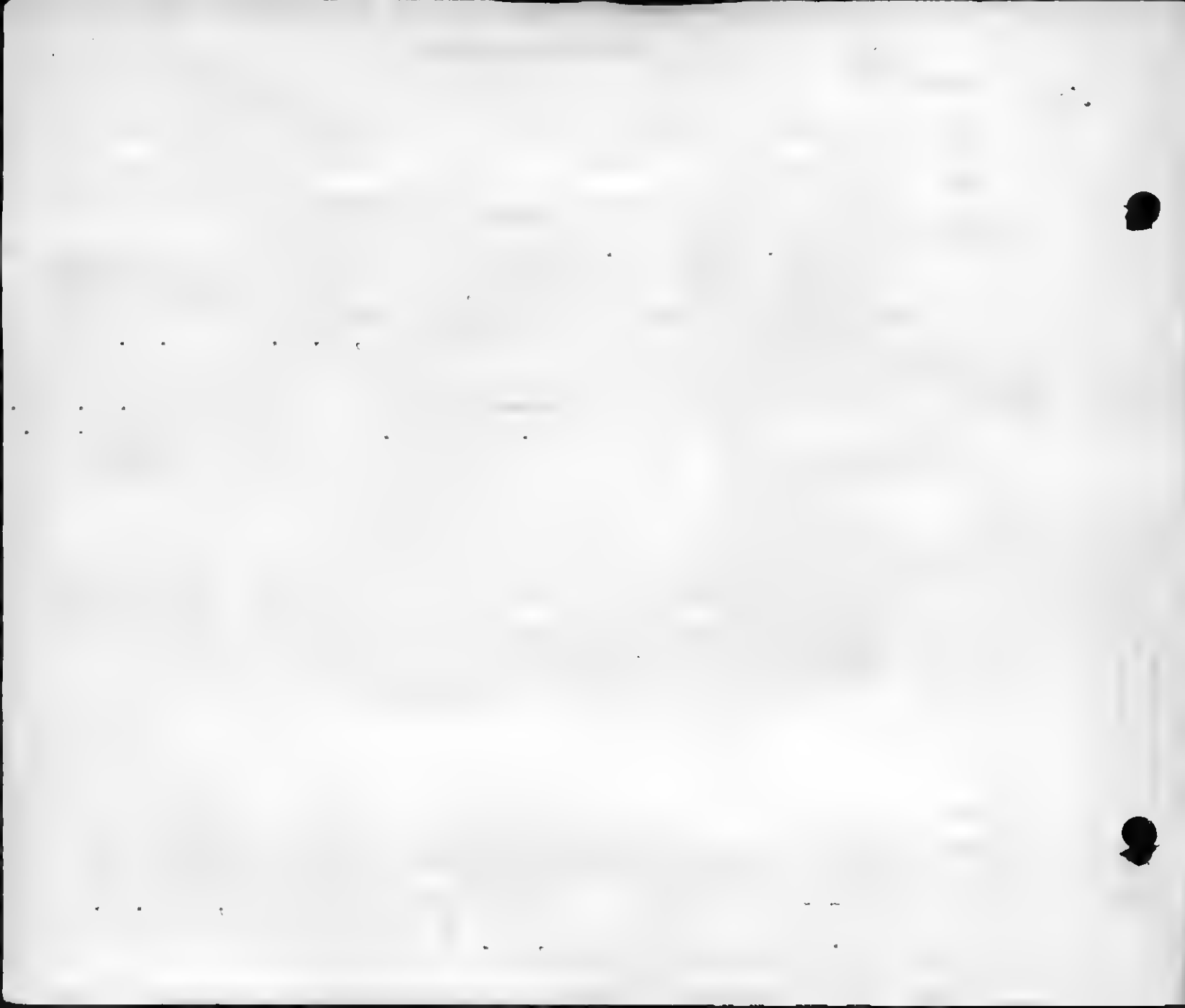
## CERTIFICATE OF DEATH

Reg. Dist. No. 65855

5868

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Chevy Chase</b>	c. LENGTH OF STAY IN 1b <b>3½ years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4604 DeRussey Parkway</b>		d. STREET ADDRESS <b>4604 DeRussey Parkway</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>M.</b> Last <b>SCHNEIDER</b>		4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>George Brandt</b>	
14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Daughter</b> <b>Mrs. Erling B. Saxhaug</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia, left, acute</b> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis, generalised.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days.</b> <b>synst</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1946</b> to <b>May 6, 1961</b> , that I last saw the deceased alive on <b>May 5, 1961</b> , and that death occurred at <b>9:30 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4740 Chevy Chase Dr.</b> DATE SIGNED <b>5.6.61</b>			
ACTUAL SIGNATURE <b>Stewart Clapp</b> M.D.		PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b> <b>Chevy Chase, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-9-61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 9 '61</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>L. K. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

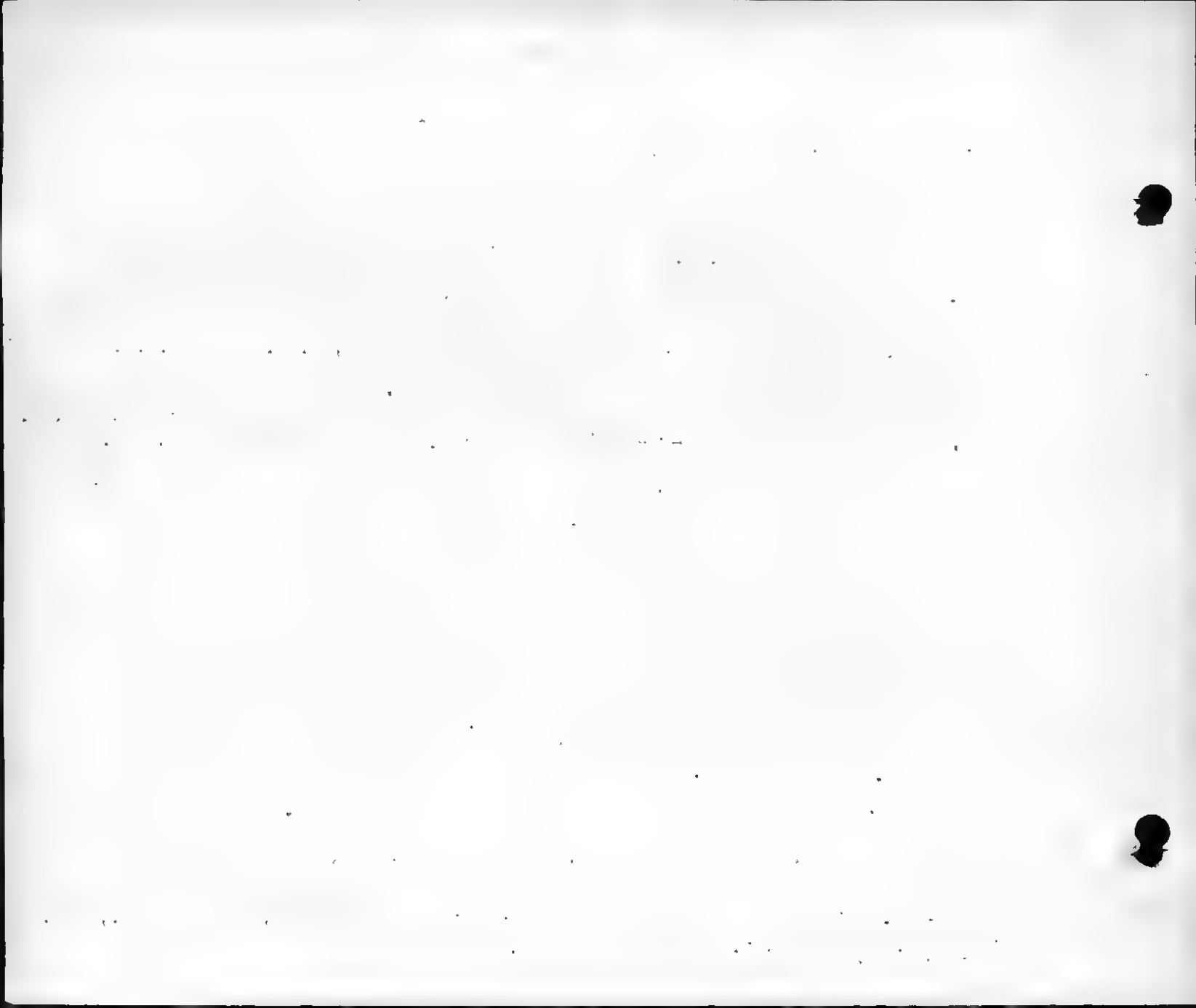


5865

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit-Burial 5/16/61</b>	22b. DATE THEREOF <b>5/16/61</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Hill Cemetery</b>	22d. LOCATION (City, town, or county) <b>Deep River</b>	(State) <b>Conn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b> <i>Raymond A. Zappa</i>		ADDRESS <b>Deep River, Conn.</b>	24a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>	24b. REGISTRAR'S SIGNATURE <i>William J. King</i>

VS A15 (4)  
15M 9/58





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5870

05857

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>41 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>2113 Payers Mill Road</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Louis Frank SHABEK</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>May 17 1961</b>	
<b>5. SEX</b> <b>Male</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>10-29-88</b>	
<b>9. AGE</b> (in years last birthday) <b>72 yrs</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Mariner</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U. S. Navy</b>	
<b>11. BIRTHPLACE</b> (County & State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James SHABEK</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary SMITH</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW #1</b>			
<b>16. SOCIAL SECURITY NO</b> <b>577-48-4778A (W)</b> <b>17. INFORMANT</b> <b>Mrs. Mary L. Shabek, same as #2 above</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of</b> (b) <b>Carcinoma of pancreas</b> (c) <b>cause lost.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1. (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State) <b>April 6 1961 to May 17 1961</b>	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 6 1961</b> to <b>May 17 1961</b> , that (we) saw the deceased alive on <b>May 17 1961</b> , and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>C. W. Bramlett</b>		<b>22b. DATE SIGNED</b> <b>5-18-61</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>C. W. BRAMLETT, LT, MC, USN</b>		<b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial-Shipment</b>		<b>23b. DATE THEREOF</b> <b>5/19/61</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Magnolia Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Defuniak Springs Florida</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W.E. Pumphrey</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE MAY 23 '61</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>		<b>25c. ADDRESS</b> <b>Silver Spring, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

after

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5871 05855

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN b 7 1/2  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Elizabeth's

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 3602 - Kirt St.

3. NAME OF DECEASED (Type or print) Edward H. Shorman  
First Middle Last

4. DATE OF DEATH May 19 1961  
Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 9/14/101  
WIDOWED ☐ DIVORCED ☐ Last birthday Years Months Days Hours Mins.

9. AGE (In years if UNDER 1 YEAR IF UNDER 24 HRS.) 50 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of work or life, even if retired) Clerk 10b. KIND OF BUSINESS OR INDUSTRY Woodward & Lothrop 11. BIRTHPLACE (County & State, or foreign country) England 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George E. Shorman 14. MOTHER'S MAIDEN NAME Stella Shorman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Stewart Clapp Address 4740 Chevy Chase Dr.

18. CAUSE OF DEATH (Enter on y one cause pertinent for (a), (b) and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral thrombosis, left  
Conditions, if any, which gave rise to immediate cause (b) Cerebral arteriosclerosis  
(a), stating the underlying cause last. (c) Essential Hypertension, severe  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis, old.  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ INTERVAL BETWEEN ONSET AND DEATH 12 hrs.

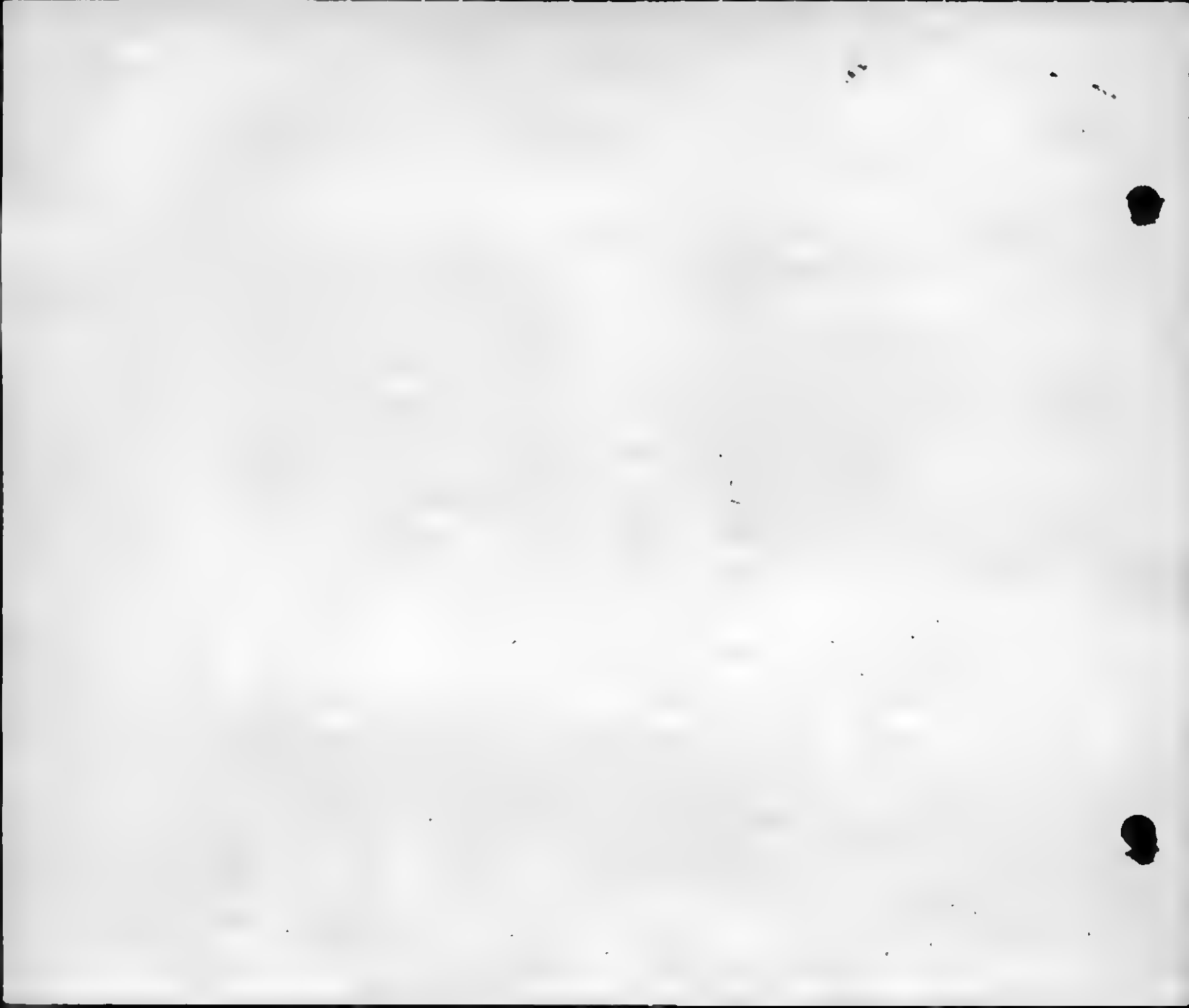
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950 to May 19, 1961, that (I) (we) last saw the deceased alive on May 19 1961, and that death occurred at 6:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE Stewart Clapp M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 5.19.61  
22c. PHYSICIAN'S NAME (Type) Stewart Clapp 22d. ADDRESS 4740 Chevy Chase Dr.

23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 23b. DATE THEREOF 5/23/61 23c. NAME OF CEMETERY OR CREMATORY Ft. Hill Cemetery 23d. LOCATION (City, town or county) (State) Auburn, New York

24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 25a. REC'D BY REGISTRAR MAY 23 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Pinaud



# 1 FOR STATE HEALTH DEPT.

TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

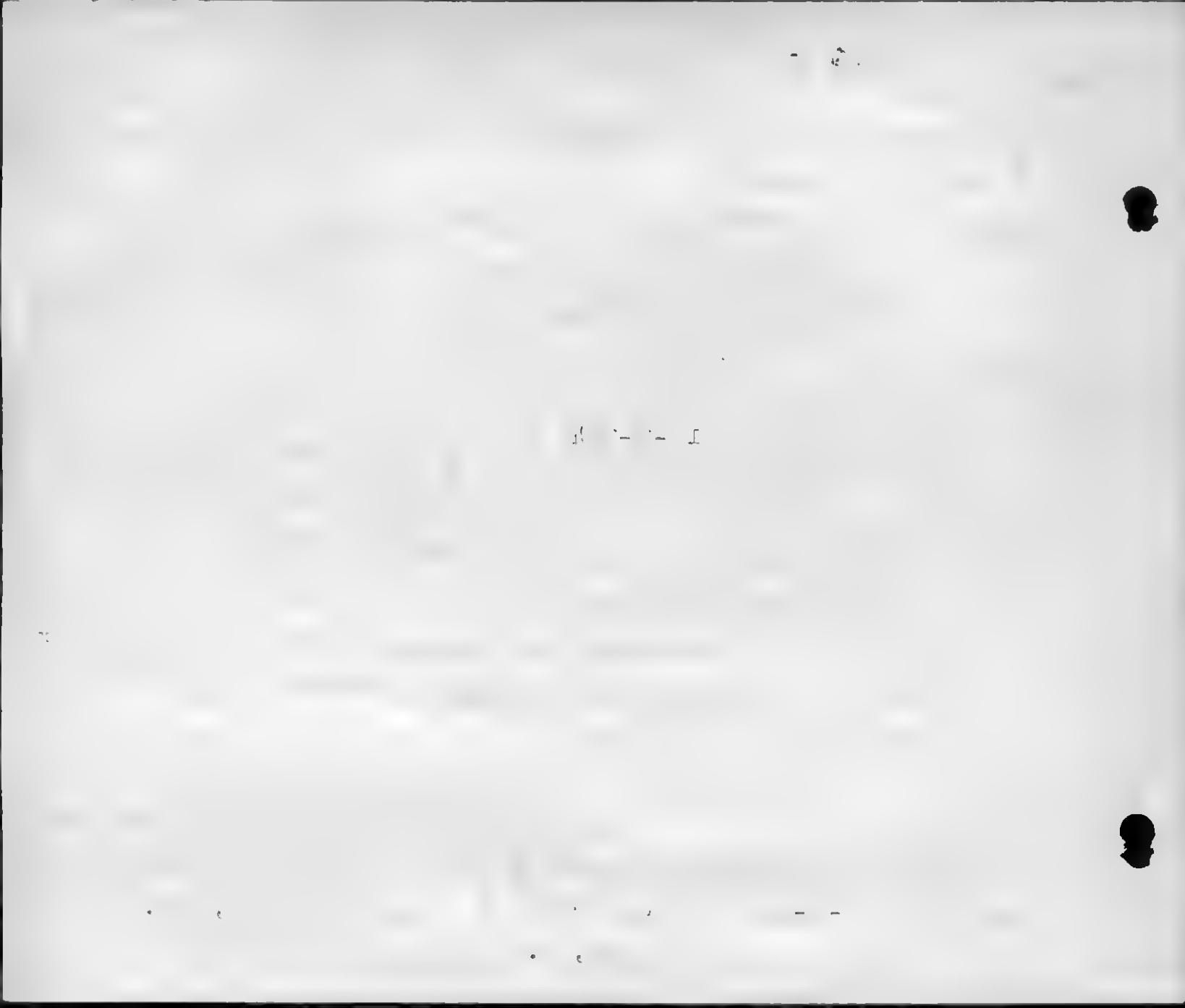
## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 5872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05859

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunshine</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R-1 Brookville</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunshine</u> d. STREET ADDRESS <u>R-1 Brookville</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert Murphy Shearer</u>		4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>	
13. FATHER'S NAME <u>Charles Shearer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Murphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>185-30-3884</u>	
17. INFORMANT <u>Emilie J. Campbell</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> Conditions, if any, which gave rise to immediate cause (b) <u>Shot gun wound of skull</u> causing the underlying cause last (c) <u>976X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>Interval between onset and death sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day Year <u>2 May 1961</u>		20d. INJURY OCCURRED <u>at work</u> <input checked="" type="checkbox"/> <u>at home</u> <input type="checkbox"/> <u>on street</u> <input type="checkbox"/> <u>in vehicle</u> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Sunshine</u> (County) <u>mmg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5-24-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Waterford</u>		22d. LOCATION (City, town, or country) <u>East Waterford, Penn.</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR <u>Francis X Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAY 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Hana</u>	

(M)

(I)



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

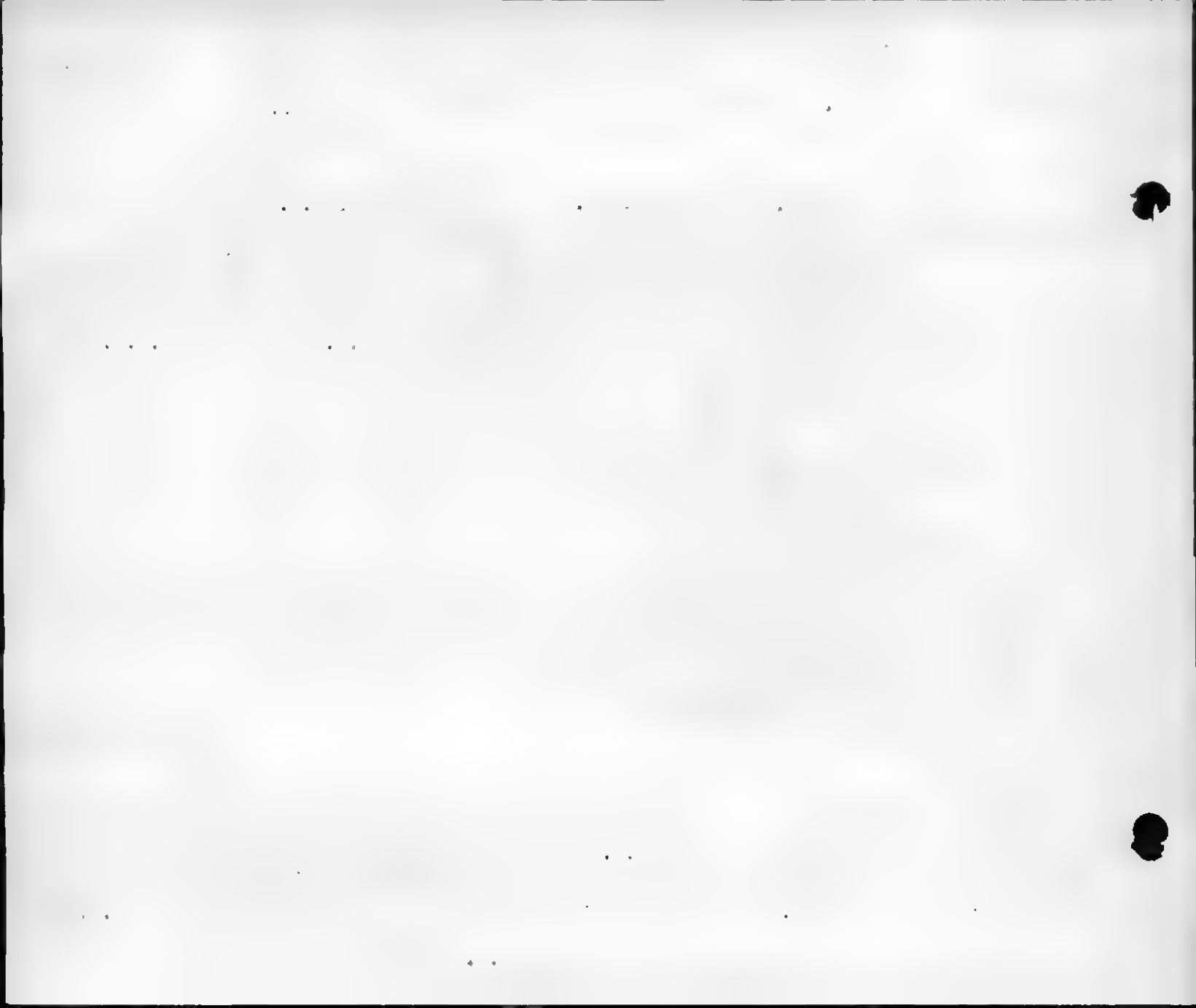
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5873

058611

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District Of Columbia</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>6439 2nd Place, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>None</b> Last <b>Sindler</b>		4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1959</b>
9. AGE (In years last birthday) <b>1</b> yrs.		10. IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Sindler</b>		14. MOTHER'S MAIDEN NAME <b>Marilyn Friedman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Records</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>289.0</b> IMMEDIATE CAUSE (a) <b>Niemann-Pick Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>12 mos.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 20</b> <b>1961</b> to <b>May 25</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>May 25</b> <b>1961</b> , and that death occurred at <b>2:15 AM</b> from the causes and on the date stated above		22a. SIGNATURE <b>Alexander Deutsch M.D.</b>	
22b. DATE SIGNED <b>5-25-61</b>		22c. PHYSICIAN'S NAME (Type) <b>Alexander Deutsch M.D.</b>	
22d. ADDRESS <b>The Clinical Center National Institutes Of Health Bethesda 14, Maryland</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 25, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Beth David Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Elmont, Long Island N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>		ADDRESS <b>4217 9th Street N.W.</b>	
25a. REC'D BY REGISTRAR <b>MAY 29 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

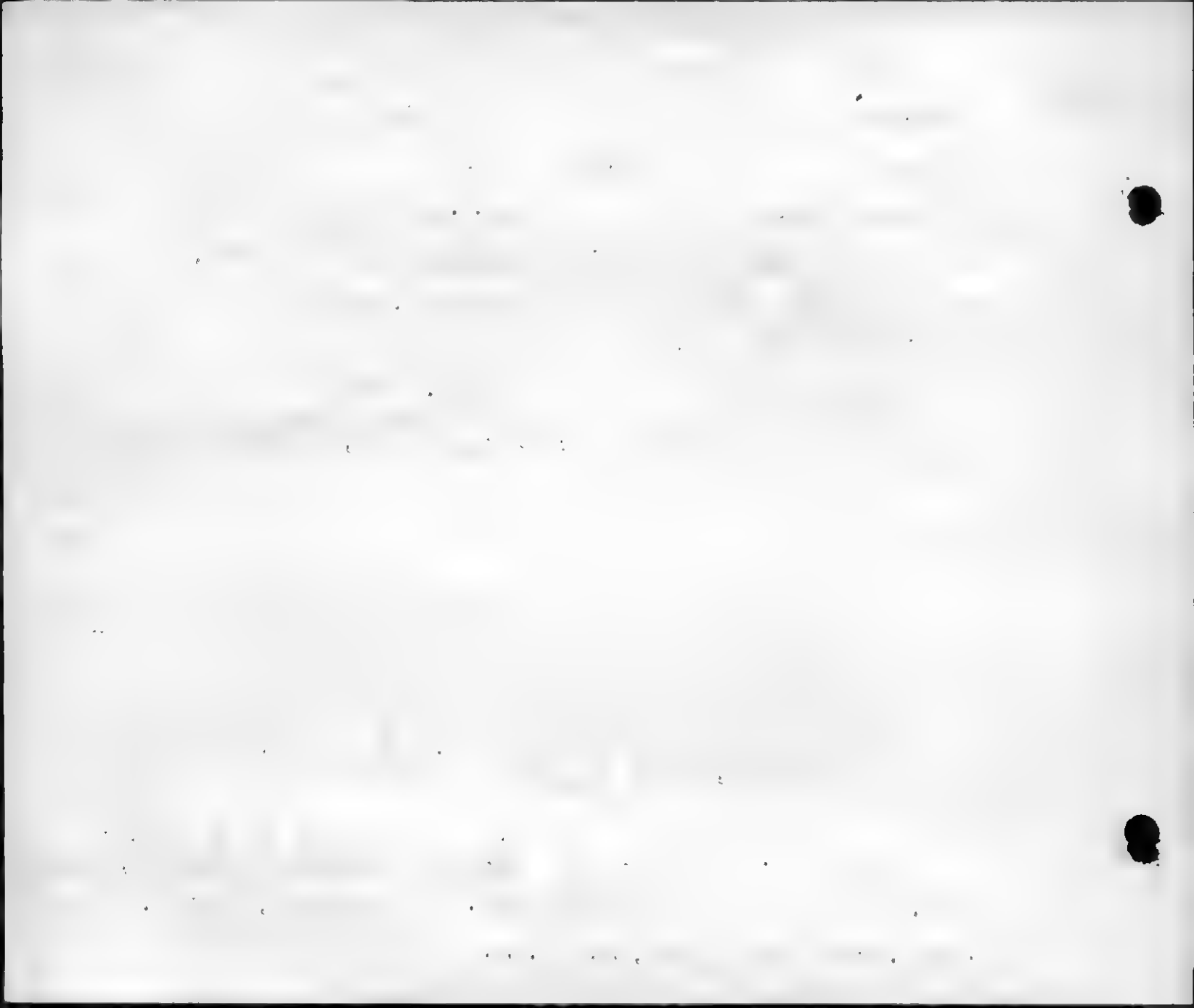
CERTIFICATE OF DEATH

5874

Item 230 x d, Film 600 5/15/61 16x

5586

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>21 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Virginia</b> b COUNTY <b>Loudoun</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aldie</b> d. STREET ADDRESS <b>P.O. Box 171</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Nina</b> Middle <b>Mario</b> Last <b>Smallwood</b>		4. DATE OF DEATH Month <b>May 8,</b> Day <b>19</b> Year <b>61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 25, 1956</b>
9. AGE (In years last birthday) yrs <b>4</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Smallwood</b>		14. MOTHER'S MAIDEN NAME <b>Ruby M. Poston</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram negative septicemia</b> DUE TO Cardiac, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Acute lymphatic leukemia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>he</b> (this hospital) attended the deceased from <b>April 17, 1961</b> to <b>May 8, 1961</b> that <b>he</b> (we) last saw the deceased alive on <b>May 8, 1961</b> , and that death occurred at <b>1:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard E. Rieselbach</b>		22b. DATE SIGNED <b>5/8/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard E. Rieselbach, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial.</b>	23b. DATE THEREOF <b>5/10/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Abenszer Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Round Hill, Virginia. U. S. 1</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Birch's</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 10 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>S. S. K.</b>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5875  
1. PLACE OF DEATH  
a. COUNTY Montgomery  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN b. MARYLAND  
d. STREET ADDRESS 4712 Smith Chelsea Lane  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐  
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 4712 Smith Chelsea Lane  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐  
3. NAME OF DECEASED (Type or print) Harvey L. Smith  
4. DATE OF DEATH May 20 1961  
5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 2/28/1897  
9. AGE (in years) 72 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired  
11. BIRTHPLACE (County & State or foreign country) Georgia 12. CITIZEN OF WHAT COUNTRY? U.S.  
13. FATHER'S NAME Robert L. Smith 14. MOTHER'S MAIDEN NAME Frances T. Smith  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 15-111111 17. INFORMANT Frances T. Smith Address 15-111111  
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial infarction  
(b) Coronary atherosclerosis  
(c) Chronic hypertension  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. None  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐  
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)  
21. I certify that (I) (this hospital) attended the deceased from... to... that (I) (we) last saw the deceased alive on... 1961, and that death occurred at... M, from the causes and on the date stated above.  
22a. SIGNATURE Robert A. Pumphrey M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐  
22b. DATE SIGNED May 20 1961  
22c. PHYSICIAN'S NAME (Type) Robert A. Pumphrey ADDRESS 4714 Cherry Lane Dr. Bethesda, Md.  
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 5/24/61  
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. 23d. LOCATION (City, town or county) (State) Arlington, Virginia  
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland  
25a. REC'D BY REGISTRAR May 23 '61 25b. REGISTRAR'S SIGNATURE Arthur L. House



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

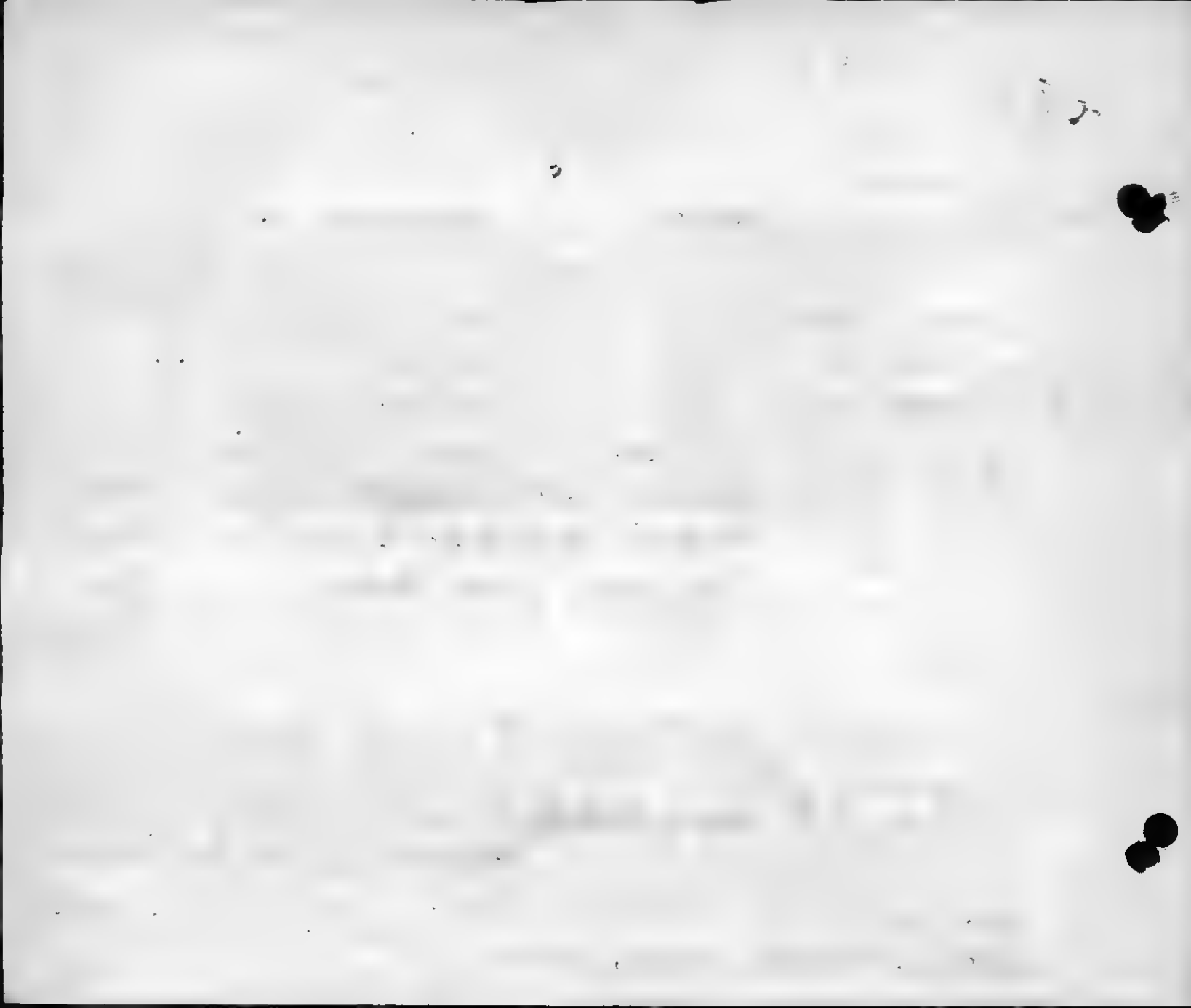
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5876

05863

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN b. <b>45 days</b>		d. STREET ADDRESS <b>5117 Scarsdale Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Julia Smith</b>		4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/9/01</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b>61</b> Min.	
11. BIRTHPLACE (County & State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Ludwig Pitsch</b>		14. MOTHER'S MAIDEN NAME <b>Julia Ann Krompöst</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Unknown Son Robert Smith 3900 Tenlow Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Increased Intracranial Pressure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Cerebral Metastatic Disease</b> (c) <b>Carcinoma of the Breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 mo.</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>10</b> a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) (County) (State) <b>Washington, D.C.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2 - 1</b> , 19 <b>61</b> , to <b>5 - 10</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>5 - 9</b> , 19 <b>61</b> , and that death occurred at <b>5 - 10</b> , 19 <b>61</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Francis C. Mayle</b>		22b. DATE SIGNED <b>5/10/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Francis Mayle</b>		22d. ADDRESS <b>8218 Wisconsin Ave Bethesda 14 Md</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>Bur, Transit 5/12/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grandview Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Cambria County, Penna.</b>		25a. REC'D BY REGISTRAR <b>MAY 15 61</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any delay should be noted in the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Item 18 Form 287 5-23-61

# MARYLAND STATE DEPARTMENT OF HEALTH

## Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05861

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SANITARIUM AND HOSPITAL</b>		d. STREET ADDRESS <b>10107 Greenock Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Phyllis Wauna Snow</b>		4. DATE OF DEATH <b>May 5 19 61</b>		5. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <b>47</b> Months Days Hours Min.	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital record</b>		11. BIRTHPLACE (State or foreign country) <b>Oregon</b>	
13. FATHER'S NAME <b>William Shepherd</b>		14. MOTHER'S MAIDEN NAME <b>Jean Martin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>537-24-7372</b>		17. INFORMANT <b>Hospital record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pending Cerebral necrosis</b> DUE TO <b>Cerebral anoxia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Undetermined</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>May 5, 1961</b>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>May 9, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	
23. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>May 12 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
5879  
CERTIFICATE OF DEATH  
05865

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 day 5 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Rd.</u> d. STREET ADDRESS <u>Holly Grove Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marion B. Stewart</u> First Middle Last		4. DATE OF DEATH <u>May 21 1961</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/27/97</u> Yrs. Months Days
9. AGE (in years last birthday) <u>64</u> Yrs. Months Days		10. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Wm. Stewart</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>511-50-50, md.</u>	
17. INFORMANT <u>Ruth A. Slaughter R.F.D. #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> (b) <u>Hypertension</u> (c) <u>131X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>131X</u> DUE TO (c) <u>131X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>131X</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>61</u> , to <u>5/21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/20</u> , 19 <u>61</u> , and that death occurred at <u>5/20</u> , 19 <u>61</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Abraham W. Davis</u>		22b. DATE SIGNED <u>5/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DAVIS</u>		22d. ADDRESS <u>917 Pershing Dr. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE WHEREOF <u>5/26/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Church.</u>		23d. LOCATION (City, town or county) (State) <u>Highland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 29 '61</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>6 hrs.</u>		d. STREET ADDRESS <u>1901 Davis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Convalescent Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>(Stilmar) Clara B. Stilmar</u>		4. DATE OF DEATH Month Day Year <u>May 28 1961</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 15, 1878</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housew. &amp; - teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Bennett</u>		14. MOTHER'S MAIDEN NAME <u>Emmaline Houx</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT (daughter) <u>Mrs. Edward Christianson</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>May 28 1961</u> , that (I) (we) last saw the deceased alive on <u>May 25 1961</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Whitbeck MD</u>		22b. DATE SIGNED <u>5-29-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Whitbeck</u>		22d. ADDRESS <u>7717 Carroll Ave, Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>May 29 - 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Kline</u>		25a. REC'D BY REGISTRAR <u>MAY 31 '61</u>	
ADDRESS <u>254 Carroll St. N.B.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5880

05867

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Germantown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		e. STREET ADDRESS <i>The Marylander</i>	
3. NAME OF DECEASED (Type or print) <i>Ethel Mary K. Storck</i>		4. DATE OF DEATH <i>May 1</i> 1961	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 27 1877</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <i>New York</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Martin Mapes</i>		14. MOTHER'S MAIDEN NAME <i>Hattie</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-37-3792</i>	
17. INFORMANT <i>Ethel H. Storck</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable myocardial infarction</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Intoxicant medication over dose (ins)</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None of significance</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/23</i> 19 <i>57</i> , to <i>5/1</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>5/1</i> 19 <i>61</i> , and that death occurred at <i>8:30</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>John P. Martin, M.D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>JOHN P. MARTIN, M.D.</i>		22d. ADDRESS <i>MEDICAL CENTER, SANDY SPRING</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>May 4, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>National Memorial Park</i>	23d. LOCATION (City, town, or county) (State) <i>Fairfax Co. Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Wacker</i>		25a. REC'D BY REGISTRAR <i>DATE MAY 3 '61</i>	
ADDRESS <i>254 Capital H. New Hko</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

MEDICAL CERTIFICATION

(M)

(I)



TO DEATH. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5882

05869

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1912 So Wilson</u> c. LENGTH OF STAY IN lb <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>IOWA</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MASON CITY</u> d. STREET ADDRESS <u>52X-3</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>VICTOR WARREN SWARTZ</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>1</u> Year <u>1961</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>2/22/1887</u>
<b>9. AGE</b> (In years last birthday) <u>74</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY</b>
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MASON CITY, IOWA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>ANTHONY CASPER SWARTZ</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET COOK</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>482-32-1798</u>	
<b>17. INFORMANT</b> <u>CHARLOTTE SWARTZ</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary emboli, multiple</u> DUE TO (b) <u>1-3 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>multiple superficial gastric ulcers</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>	
<b>(State)</b>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>12 April 1961</u> <b>to</b> <u>MAY 1 1961</u> <b>that (I) last saw the deceased alive on</b> <u>MAY 1 1961</u> <b>and that death occurred at</b> <u>1230 AM</u> <b>from the causes and on the date stated above.</b>	
<b>22a. SIGNATURE</b> <u>Jack Crowell</u>		<b>22b. DATE SIGNED</b> <u>May 961</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>JACK CROWELL</u>		<b>22d. ADDRESS</b> <u>2025 EYE ST, NW Washington, D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried 5/4/61</u>		<b>23b. DATE THEREOF</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Park Lawn Cem.</u>		<b>23d. LOCATION (City, town or county)</b> <u>Rockville Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cherry Chase Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Wash DC</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>		<b>25c. DATE</b> <u>MAY 4 '61</u>	

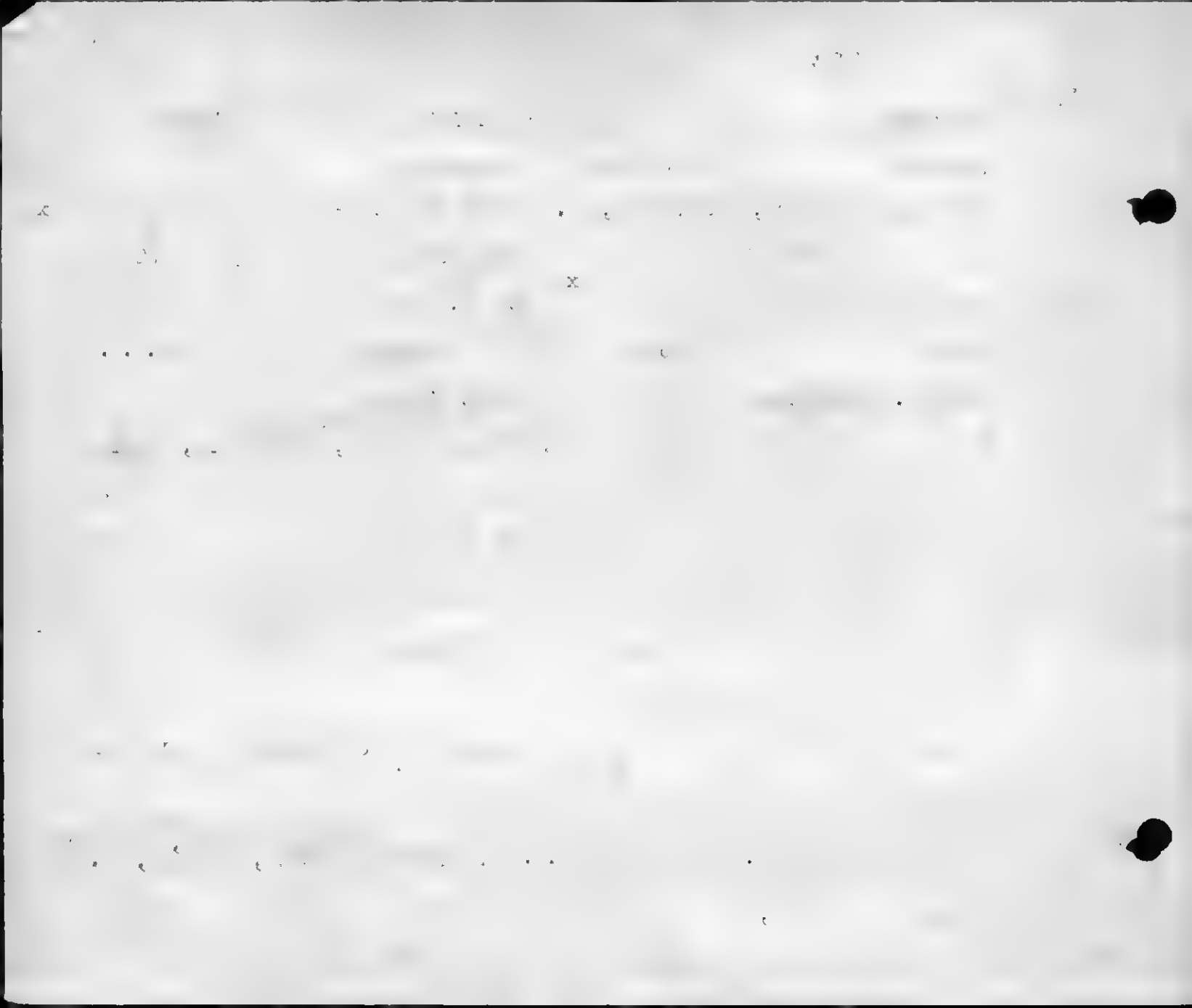
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5883 CERTIFICATE OF DEATH 05870											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Virginia</b> b. COUNTY <b>Campbell</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lynchburg</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1403 Club Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cheryl</b> Middle <b>Lynn</b> Last <b>Tarkington</b>				4. DATE OF DEATH Month <b>May</b> Day <b>22</b> Year <b>19 61</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1952</b>		9. AGE (In years last birthday) <b>8 yrs.</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>22</b> Hours <b>19</b> Min. <b>61</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward H. Tarkington</b>				14. MOTHER'S MAIDEN NAME <b>Jean Richcreek</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMATION <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter on only one cause per line for (a), (b) and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Acute lymphatic leukemia</b> (c) <b>15 months</b> DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 5 minutes</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>May 16 61 to May 22 61</b>		20g. (County) <b>61</b>	
21. I certify that <b>HE</b> (this hospital) attended the deceased from <b>May 16 61</b> to <b>May 22 61</b> , that <b>he</b> (we) last saw the deceased alive on <b>May 22 61</b> , and that death occurred at <b>11:20 PM</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Richard E. Rieselbach</b>				22b. PHYSICIAN'S NAME (Type) <b>Richard E. Rieselbach, M.D.</b>				22c. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md.</b>		22d. DATE SIGNED <b>5/22/61</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>May 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		23d. LOCATION (City, town or county) <b>Lynchburg, Virginia</b>		23e. (State) <b>Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. D. Lingard Inc</b>				24b. ADDRESS <b>Lynchburg, Virginia</b>				25a. REC'D BY REGISTRAR <b>DATE MAY 25 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

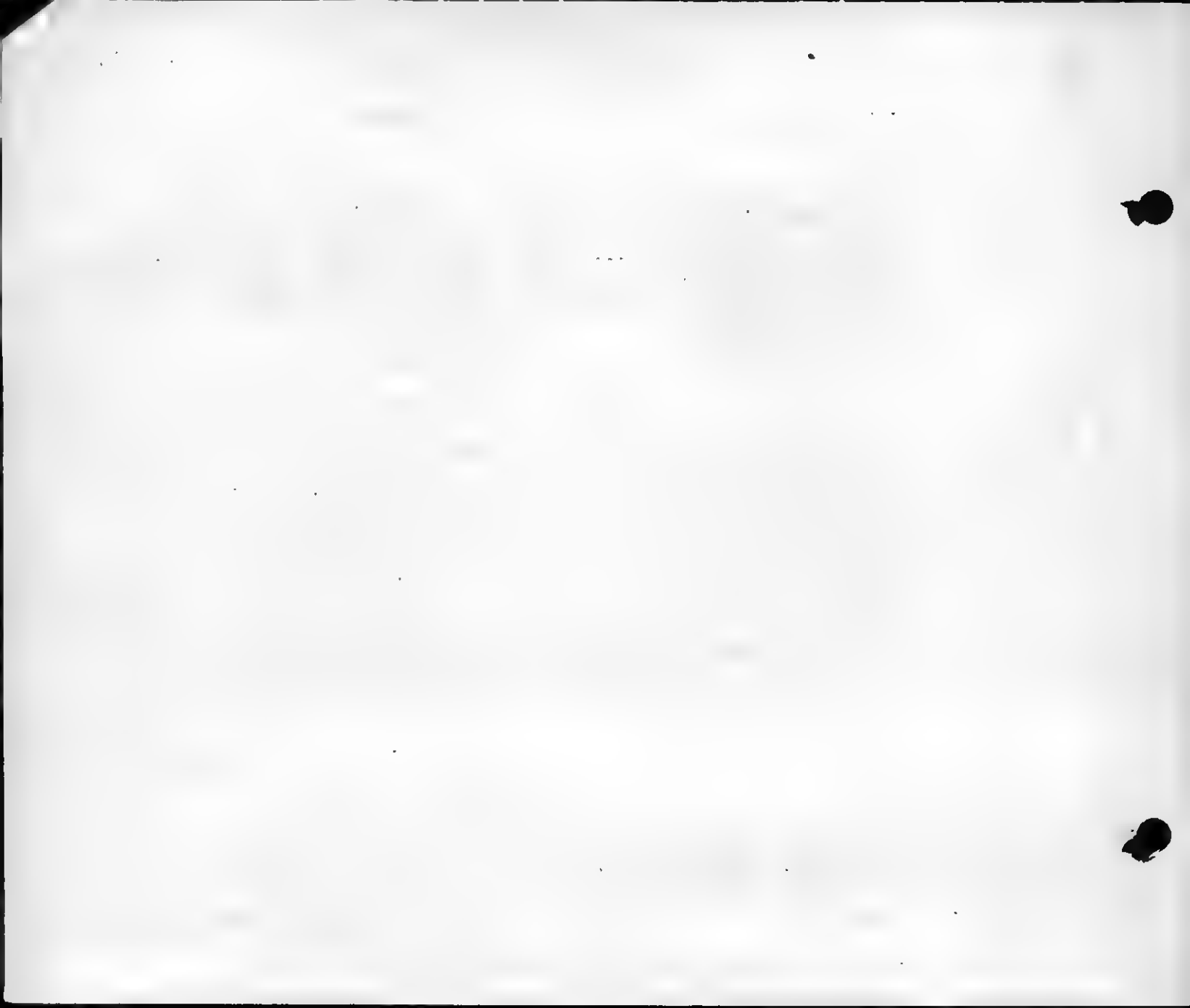
CERTIFICATE OF DEATH

5884

05871

Item 9 Film 0287 5/17/61

1 PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>75 MINUTES</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>DISTRICT</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY GENERAL HOSPITAL</b>				e. STREET ADDRESS <b>2920 MCKINLEY ST., N. W.</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>EVELYN</b>		First <b>---</b>		Middle <b>---</b>		Last <b>TECKEMEYER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>11</b> Year <b>1961</b>	
5 SEX <b>FEMALE</b>		6 COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 12, 1906</b>		9 AGE (In years last birthday) <b>54</b> yrs	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <b>TENNESSEE</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>MATTINGLY</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17 INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CORONARY SCLEROSIS</b> (b) <b>ACUTE PULMONARY EDEMA</b> (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>2:50 PM 5/11, 1961</b> to <b>3:36 PM 5/11 1961</b> , that (I) (we) last saw the deceased alive on <b>5/11 1961</b> , and that death occurred at <b>3:36 PM</b> , from the causes and on the date stated above									
22a SIGNATURE <b>A. D. Bonifant, M. D.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <b>5/11/61</b>			
22c PHYSICIAN'S NAME (Type)				22d ADDRESS <b>SANDY SPRING, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City, town, or county) (State)			
<b>Cremation</b>		<b>5/13/61</b>		<b>Fort Lincoln</b>		<b>Bladensburg Rd., Md</b>			
24 FUNERAL DIRECTOR'S SIGNATURE <b>Cheng Cheng James Norrie, Frank De</b>				ADDRESS <b>5103 Hwy 401 N. Wash Dc</b>		25 REC'D BY REGISTRAR DATE <b>MAY 15 '61</b>		25b REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5885

05872

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>...</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven Convalescent Home</u>				e. STREET ADDRESS <u>6629-81st St, Cabin John, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Thornton</u> Middle <u>B</u> Last <u>Titus</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1875</u>	9. AGE (In years last birthday) <u>85</u> yrs	10. UNDER 1 YEAR Months <u>...</u> Days <u>...</u>	11. UNDER 24 HRS Hours <u>...</u> Min <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>...</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Titus</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann McKimmy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>212-24-4693</u>		17. INFORMANT <u>Elizabeth Witt-6629-81st St. Cabin John, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 32X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GENERAL</u> DUE TO (c) <u>...</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>5 yr.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>...</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1959</u> to <u>MAY 22, 1961</u> , that (I) (we) last saw the deceased alive on <u>MAY 21, 1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Leo M. Curtis</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>				22d. ADDRESS <u>8218 WISCONSIN AVE., BETHESDA, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/25/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d. LOCATION (City, town, or county) (State) <u>Leesburg, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> ADDRESS <u>1331 F. Montg. Ave. Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>...</u> DATE <u>MAY 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	

MEDICAL CERTIFICATION

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 3-87 5/22/61

## CERTIFICATE OF DEATH

Reg. Dist. No.

05873

5886

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRLAND NURSING HOME</b>		e. STREET ADDRESS <b>8110 New Hampshire Ave</b> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>FRANCES ULRICH</b>		4. DATE OF DEATH Month Day Year <b>MAY 16 1961</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 1897</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESWOMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RUSSIA</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SOLOMON KRASNER</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH EISENBERG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>577-36-2724</b>	
17. INFORMANT <b>STANLEY K. ULRICH</b>		Address <b>8110 NEW HAMPSHIRE AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of the sigmoid</b> <b>153</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>6 MOS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p m <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/15</b> , 19 <b>60</b> to <b>5/15</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>5/15</b> , 19 <b>61</b> , and that death occurred at <b>8 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Beth Kaler</b>		DATE SIGNED <b>BENNETT A. ROBIN, M.D.</b>	
PHYSICIAN'S NAME (Type) <b>BETH KALER</b>		<b>317 UNIV. BLVD. EAST SILVER SPRING, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/18/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ELMONT-L.I., N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b>		ADDRESS <b>3501-14 STNW</b>	
24a. REC'D BY REGISTRAR <b>MAY 18 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE-  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, it is necessary, please include the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
FURNAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5887

05873

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>De.</u> b. COUNTY <u>De.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ukeshington</u>	
c. LENGTH OF STAY IN 1b <u>1 mo</u>		d. STREET ADDRESS <u>3847 Rockman St. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Garden Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Lawrence Vail</u>		4. DATE OF DEATH <u>May 1 1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-78</u>
9. AGE (In years) <u>82</u>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. last birthday Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Vail</u>		14. MOTHER'S MAIDEN NAME <u>Narcissa Lawrence</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>441-01-1084</u>	
17. INFORMANT <u>Nursing Home Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4 +</u> DUE TO <u>Acute Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiac - Renal disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u> <u>month</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>5/3/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>May 3 '61</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

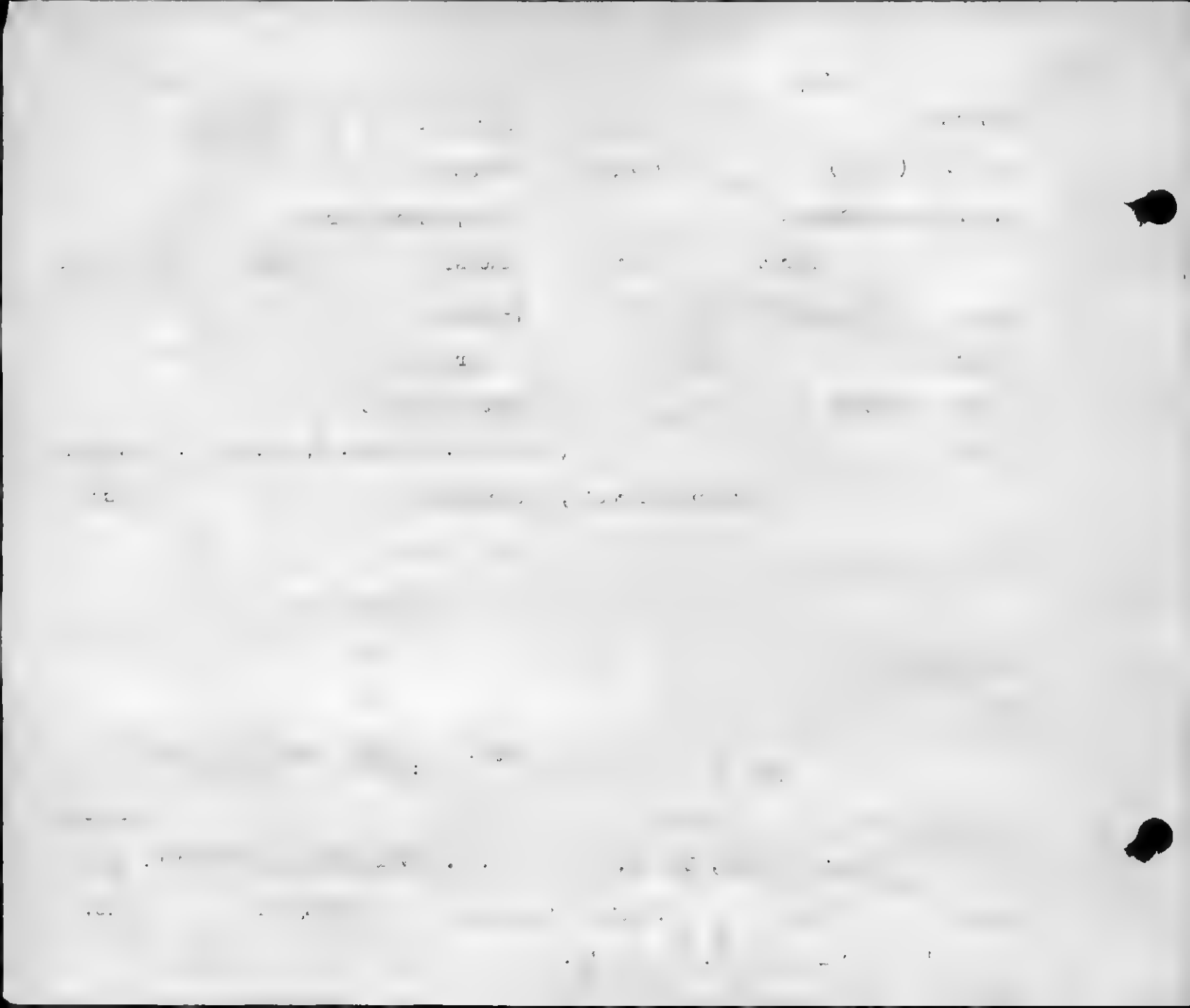
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5888 6587

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>11967 Andrew Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marin Pierre VINCENT</b>		4. DATE OF DEATH <b>May 21 1961</b>		5. AGE (In years last birthday) <b>68 yrs.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>7-20-92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>		11. BIRTHPLACE (County & State, or foreign country) <b>France</b>	
13. FATHER'S NAME <b>Desiree VINCENT</b>		14. MOTHER'S MAIDEN NAME <b>Zenaide BOUTOUS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(S) Rene N. Vincent, 2702 10th St., NE, WashDC</b>		17. INFORMANT <b>Address</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis, generalized</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>May 4 1961 to May 21 1961</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 4 1961</b> to <b>May 21 1961</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>May 21 1961</b> , and that death occurred at <b>5:27 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Robert G. Muth</b>		22b. DATE SIGNED <b>5-22-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert G. MUTH, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		22e. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Mt. Ranier, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 9,60

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FOR STATE  
HEALTH DEPT.

(M)

(T)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
5889											
1. PLACE OF DEATH											
a. COUNTY <u>Montgomery</u> MARYLAND											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>											
c. LENGTH OF STAY IN 1b <u>23 yrs</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9118 Redwood Ave</u>											
3. NAME OF DECEASED (Type or print) <u>Elliott Lambert Wallace</u>											
5. SEX <u>male</u>											
6. COLOR OR RACE <u>white</u>											
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH <u>6-8-1878</u>											
9. AGE (in years last birthday) <u>82</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Year											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov. employee</u>											
10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>											
11. BIRTHPLACE (State or foreign country) <u>Us</u>											
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Geo. M. Wallace</u>											
14. MOTHER'S MAIDEN NAME <u>Eliq. Roberts</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>											
16. SOCIAL SECURITY NO. <u>None</u>											
17. INFORMANT <u>Julia Wallace (wife)</u> Address <u>Stm 2</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u>											
(c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>											
20f. (City or town) (County) (State) <u>  </u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-27-61</u>											
Address (Street, city, town, or county) <u>  </u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>5/31/61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>											
22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>											
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>											
24a. REC'D BY REGISTRAR <u>JUN 2 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Collier S. Frank</u>											





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

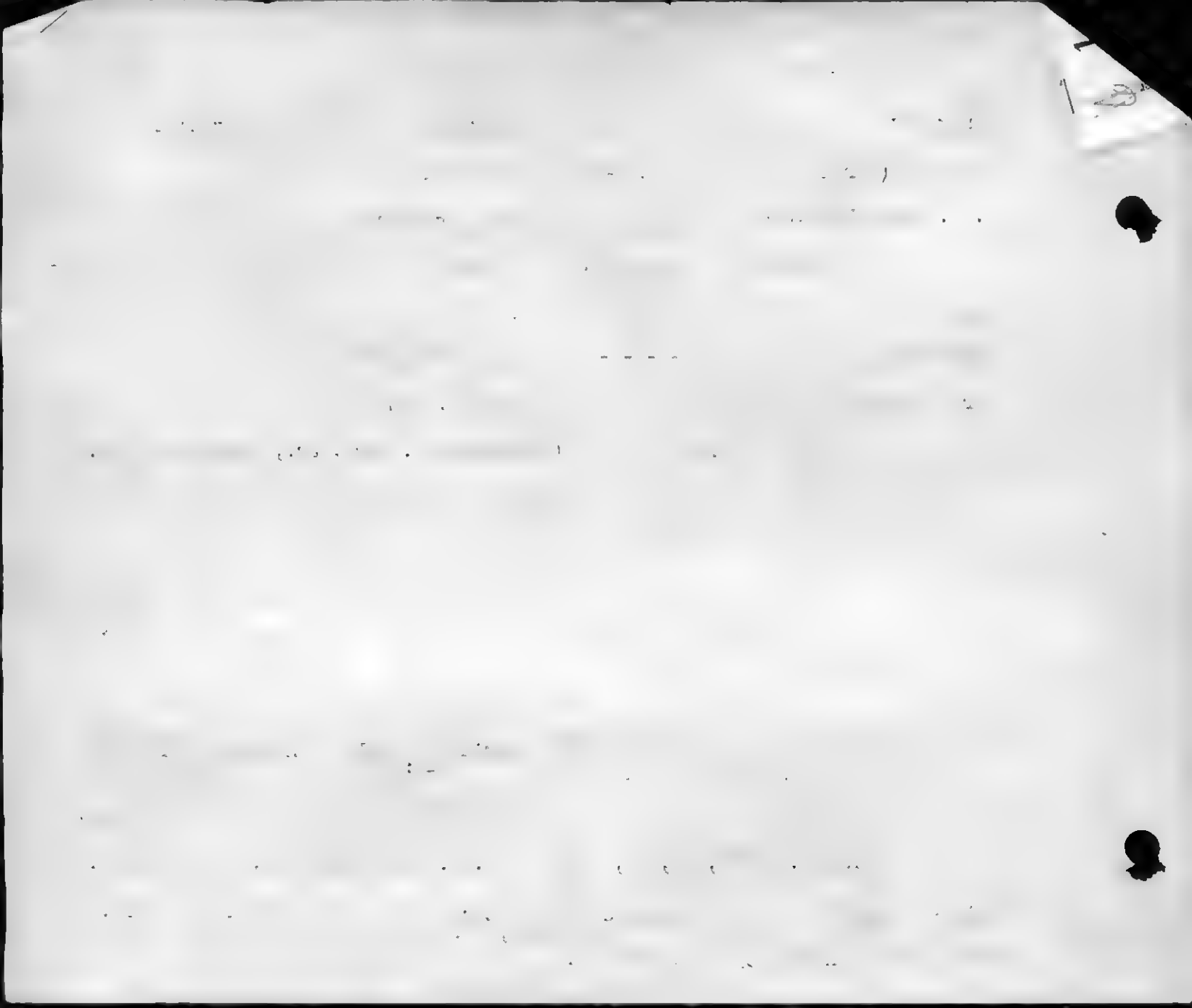
## CERTIFICATE OF DEATH

5890

45877

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Montgomery</b></p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b></p> <p>c. LENGTH OF STAY IN b. <b>35 days</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <b>Maryland</b></p> <p>b. COUNTY <b>Ann Arundel</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b></p> <p>d. STREET ADDRESS <b>407 3rd Street</b></p>	
<p>3. NAME OF DECEASED (Type or print)</p> <p style="text-align: center;">First Middle Last</p> <p><b>Hannah Catherine WERT</b></p>		<p>4. DATE OF DEATH</p> <p style="text-align: center;">Month Day Year</p> <p><b>May 19 61</b></p>	
<p>5. SEX <b>Female</b></p> <p>6. COLOR OR RACE <b>Caucasian</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>5-6-80</b></p> <p>9. AGE (In years last birthday) <b>81 yrs.</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p> <p>11. BIRTHPLACE County &amp; State, or foreign country <b>Pennsylvania</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Christ RONK</b></p> <p>14. MOTHER'S MAIDEN NAME <b>Mary E. DULL</b></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b></p> <p>16. SOCIAL SECURITY NO. <b>None</b></p> <p>17. INFORMANT <b>(S) Charles A. Wert, Jr., same as #2 above</b></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ischemic Heart Disease</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (c) <b>Stroke</b></p>			
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/></p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>			
<p>20c. TIME OF INJURY</p> <p>Hour a.m. p.m. <b>19</b></p>		<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>	
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that <b>it</b> (this hospital) attended the deceased from <b>April 14, 1961</b> to <b>May 19, 1961</b>, that <b>it</b> (we) last saw the deceased alive on <b>May 19, 1961</b>, and that death occurred at <b>12:35AM</b>, from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <b>[Signature]</b></p> <p>22c. PHYSICIAN'S NAME (Type) <b>James M. YOUNG, LT, MC, USN</b></p>		<p>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/></p> <p>22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b></p> <p>23b. DATE THEREOF</p>		<p>23c. NAME OF CEMETERY OR CREMATORY <b>Maple Grove Cemetery</b></p> <p>23d. LOCATION (City, town or county) (State) <b>Elizabethville Pa.</b></p>	
<p>24. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b></p> <p>ADDRESS <b>Murphy Funeral Home, 3524 Columbia Pike, Arlington, Va.</b></p>		<p>25a. REC'D BY REGISTRAR <b>MAY 23 '61</b></p> <p>25b. REGISTRAR'S SIGNATURE <b>[Signature]</b></p>	

TO HO: 1. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



5994

Charles L. Kinn

VR A15 (4)  
15M 9/60

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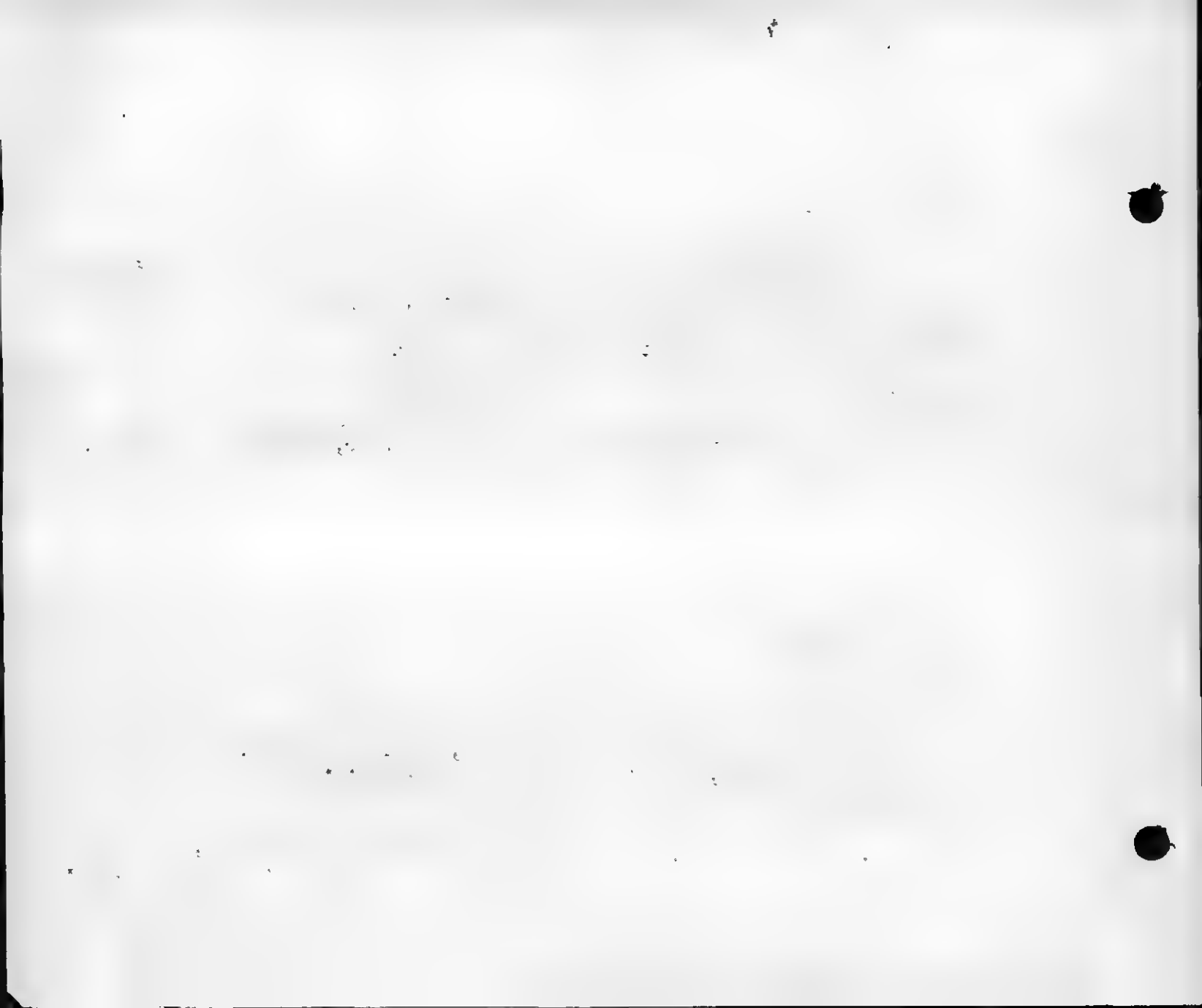
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5892

0587

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clinton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>				d. STREET ADDRESS <b>Box 112</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frank Levy White</b>				4. DATE OF DEATH Month Day Year <b>May 15, 19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1899</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR: Months Days Hours		IF UNDER 24 HRS: Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee White</b>				14. MOTHER'S M.A.DEN NAME <b>Nettie Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Unavailable</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Lymphocytic leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 15, 19 61</b> to <b>May 15, 19 61</b> that (I) (we) last saw the deceased alive on <b>May 15, 19 61</b> and that death occurred at <b>2:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>R. Rieselbach</b>				22b. DATE SIGNED <b>5/15/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>R. Rieselbach M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>May 17-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		23d. LOCATION (City, town, or county) (State) <b>Clinton Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Summers Bros</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 17 '61</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be read by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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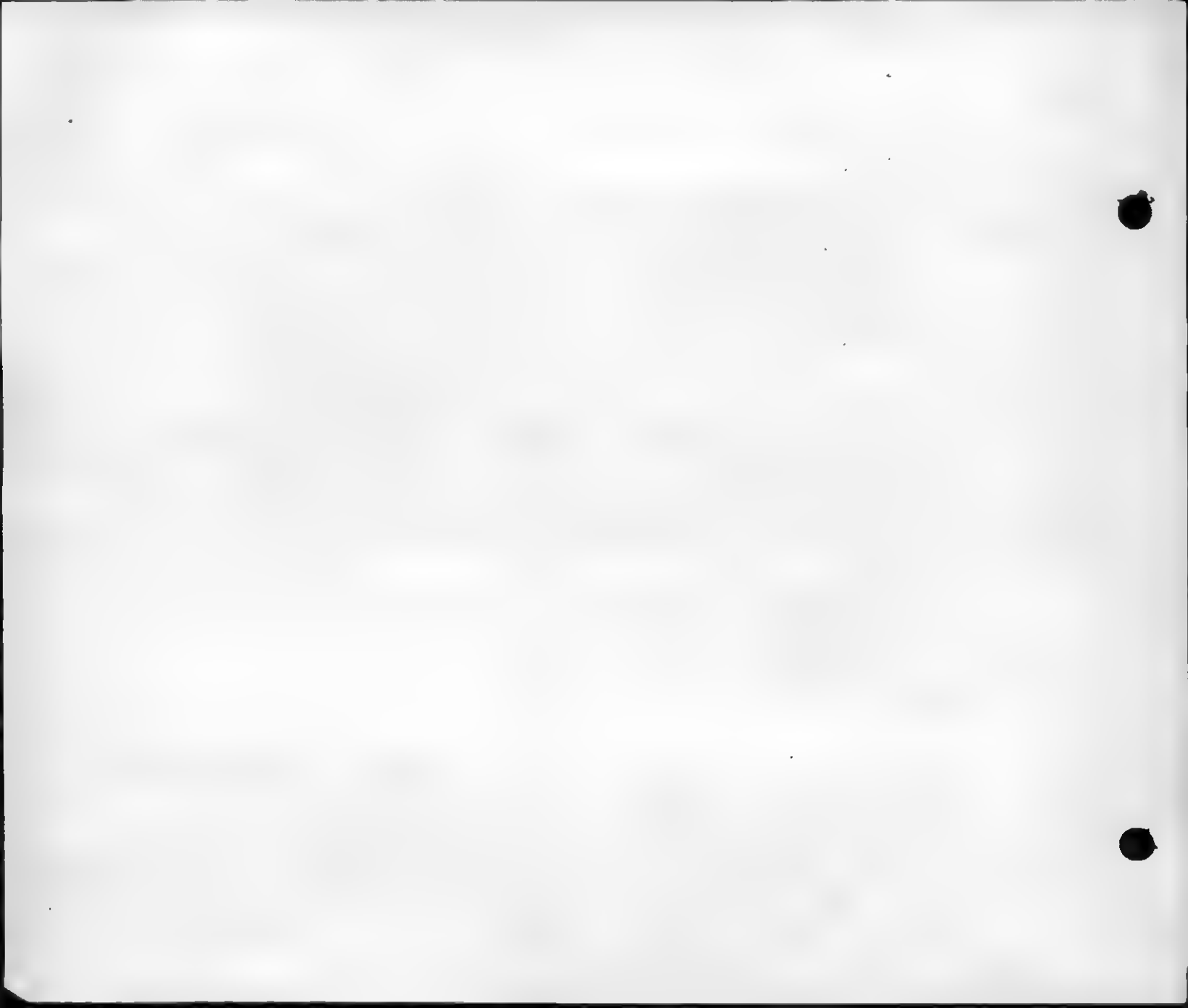
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

U58811

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7815 GREENWOOD AVE</u>				e. STREET ADDRESS <u>1 GREENWOOD AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>FLOSSIE</u> Last <u>WILLARD</u>				4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 28, 1888</u>	9. AGE (In years lost birthday) <u>72</u> yrs	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MORGANTOWN, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ZARQUELLEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. LEMON</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT <u>GEORGIA M. WILLARD, 7815 GREENWOOD AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism susp.</u> DUE TO <u>Anteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>20 yr. est.</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month <u>Jan</u> Day <u>22</u> Year <u>1960</u> Hour <u>a. m.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 22, 1960</u> to <u>May 2, 1961</u> that (I) <u>was</u> last saw the deceased alive on <u>May 2, 1961</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph F. Patten</u>				22b. DATE SIGNED <u>5/2/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>RALPH F. PATTEN M.D.</u>				22d. ADDRESS <u>8641-Colesville Road Silver Spring Md</u>			
23a. BURIAL, CREMATION (Specify)		23b. DATE THEREOF <u>MAY 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FLETCHER M. E. CEMETERY</u>		23d. LOCATION (City, town, or county) <u>MORGANTOWN W. VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Kinn</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kinn</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

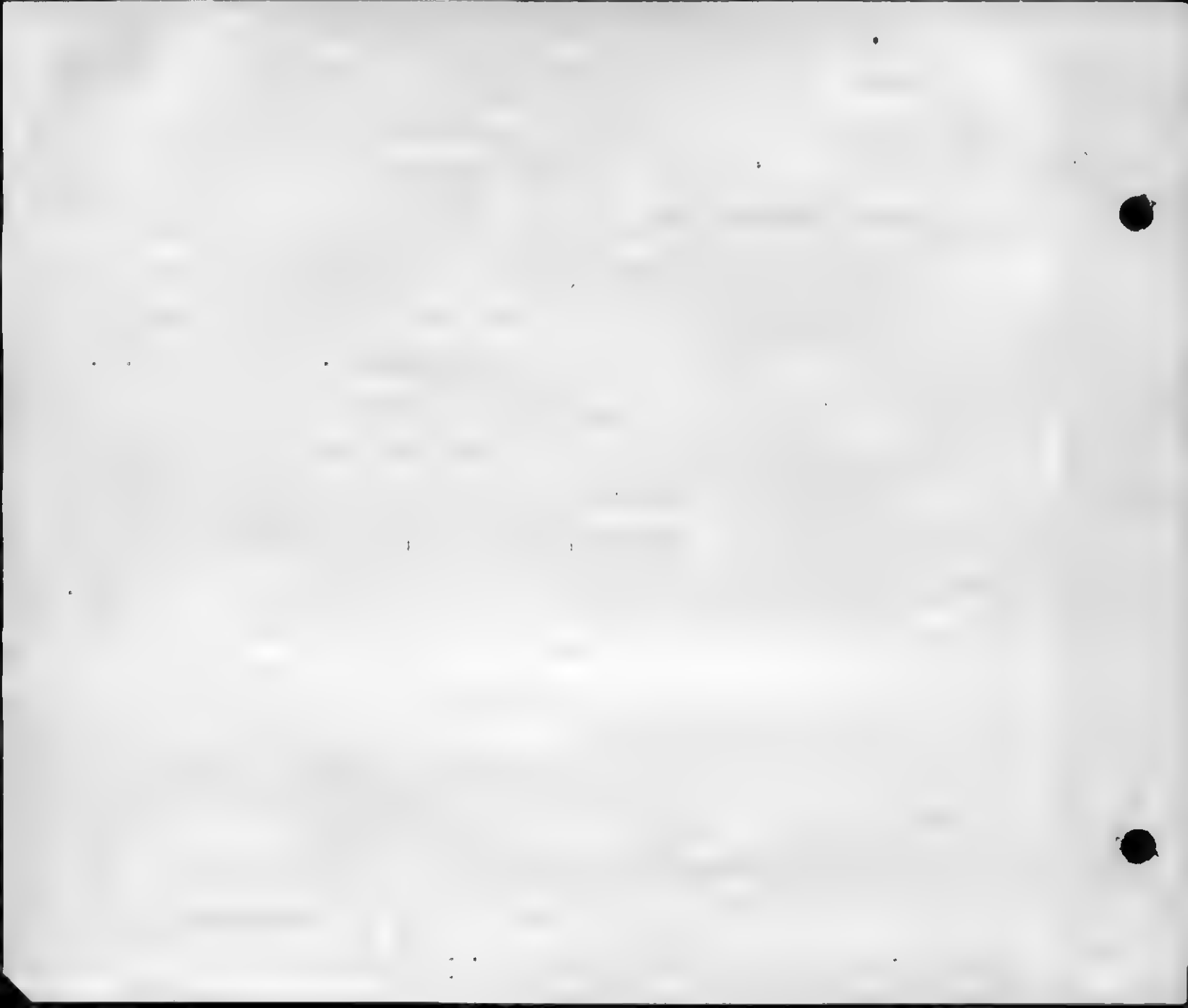
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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05881

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>NORWOOD ROAD</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) <b>GARY ROBERT WILLET</b>		f. DATE OF DEATH <b>MAY 4 1961</b>	
5. SEX <b>MALE</b>		8. DATE OF BIRTH <b>8/12/60</b>	
6. COLOR OR RACE <b>WHITE</b>		9. AGE (In years, last birthday) <b>8</b> yrs. <b>22</b> Months <b>4</b> Days <b>19</b> Hours <b>61</b> Min.	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WASHINGTON, D. C.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>ROBERT WILLET</b>		14. MOTHER'S MAIDEN NAME <b>RUTH REID</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>ITEM 2</b>	
17. INFORMANT <b>RUTH REID</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>1. 175X</b> DUE TO <b>ASPHYXIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>UPPER RESPIRATORY INFECTION</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>IN BED.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>XXXXX</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <b>May 6, 1961</b>		DATE SIGNED <b>5/4/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		Address (Street, city, town, or county)	
22d. LOCATION (City, town, or country) (State) <b>Montgomery Maryland</b>			
23. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc., 8474 Georgia Ave, S.S.</b>		24a. REC'D BY REGISTRAR <b>MAY 8 '61</b>	
ADDRESS <b>Raymond A. Zicka</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained by the hospital or attending physician, the law requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>10.0.4</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Syn. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1512 Noyes Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Josephine Williams</u> First Middle Last 4. DATE OF DEATH <u>5 3 1961</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED: <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8-6-88</u> 9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hs wf</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Dixon</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Garrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Ralph Williams</u> Address <u>10118 Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Heart Disease &amp; Hypertension</u> over 10 years DUE TO (c) <u>420-0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous Myocardial Infarction 1955 &amp; 1958</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>MAY 3</u> , 1961, that (I) (was) last saw the deceased alive on <u>May 1</u> , 1961, and that death occurred at <u>6:12</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>Warren D. Brill, M.D.</u> 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) <u>Warren D. Brill, M.D.</u> 22d. ADDRESS <u>2601-16th St. NW Wash. D.C.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>23b. DATE THEREOF</u> <u>May 6, 1961</u> <u>Fort Lincoln Mausoleum</u> <u>Prince Georges</u> <u>Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., 8434 Georgia Ave., S.S.</u> <u>Raymond A. Ziska</u> <u>MD.</u> 25a. REC'D BY REGISTRAR <u>MAY 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>William E. Thomas</u>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>8 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist. of Columbia</u> COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1321-14 Harvard St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles Palmer Wright</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>May 17 1961</u> Month Day Year		<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>colored</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>6/19/15</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>9. AGE</b> (In years, last birthday) <u>47</u> UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerical</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Govt.</u> <b>11. BIRTHPLACE</b> (County, State, or foreign country) <u>North Carolina</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Julius Wright</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Abbie Palmer</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>yes World War II</u> <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Mrs. Elizabeth McNeal - Sister</u> Address <u>(same)</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory FAILURE</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>MULTIPLE Myeloma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>UREMIA</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>November 17, 1960</u> <b>to</b> <u>May 17, 1961</u> <b>that (I) (the) last saw the deceased alive on</b> <u>May 17, 1961</u> <b>and that death occurred at</b> <u>5:00 PM</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>Jack Crowell</u> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>May 17, 1961</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>JACK CROWELL</u> <b>22d. ADDRESS</b> <u>2025 Eye St. N.W. Wash., D.C.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) _____ <b>23b. DATE THEREOF</b> <u>May 22, 1961</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u> <b>23d. LOCATION</b> (City, town or county) <u>Fort Meyer</u> <b>(State)</b> <u>Va</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Artzins Funeral Home</u> <b>ADDRESS</b> <u>389 R.I. Ave N.W.</u> <b>25a. REC'D BY REGISTRAR</b> <u>Arthur S. Kraus</u> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <u>MAY 19 61</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text at the bottom left, possibly a date or location.

Handwritten text at the bottom center, possibly a date or location.

Handwritten text at the bottom right, possibly a date or location.

Handwritten text at the very bottom, possibly a signature or name.